

## BASCOL 2025-2026 SCHOOL YEAR REGISTRATION PACKET

\*\*\*Submission of this form is not a guarantee of enrollment. Registration cannot be processed until all paperwork is complete & returned to the BASCOL Office.

There is a minimum 10-14 business day processing period before your child may begin.\*\*\*

\*\*\*A parent meeting may be required prior to completion of enrollment to discuss accommodations.\*\*\*

### 3rd Child Information

CHILD'S NAME \_\_\_\_\_ Nickname (If any) \_\_\_\_\_

Birth date \_\_\_\_\_ Age \_\_\_\_\_ Gender: M or F

School \_\_\_\_\_ Child's Grade as of Sept. 2025: \_\_\_\_\_ Classroom Teacher \_\_\_\_\_

Schedule—Circle one: AM PM BOTH or SHO PLUS\*

Days—Circle all that apply: M T W H F Desired Start Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

In order to provide your child with the best services possible please let us know, along with a brief description, if your child has any of the following conditions: (Please circle yes or no for each)

Yes or No Asthma\* \_\_\_\_\_

Yes or No Diagnosed Allergies\* \_\_\_\_\_

Yes or No Sensitivities or Intolerances \_\_\_\_\_

Yes or No Diabetes \_\_\_\_\_

Yes or No Epilepsy or Seizures \_\_\_\_\_

Yes or No Takes Regular Medication \_\_\_\_\_

Yes or No Allergic to Medications \_\_\_\_\_

Yes or No ADHD (list accommodations) \_\_\_\_\_

Yes or No Court/Custody Issues (if yes please attach a copy of court/custody papers)

*\*\*Court Orders must be provided to the BASCOL Office to legally prevent a parent from having access to and/or picking up a child\*\**

Yes or No Receives services at school (speech, OT, PT, etc.) has IEP, 504 plan, or behavior plan.\*\*\*

Please explain and attach copy of plan. \_\_\_\_\_

Yes or No Is your child able to successfully participate in a program with 1 adult per group of 10 children?

Yes or No Other (Please explain) \_\_\_\_\_

\*No medication needed while at BASCOL. I understand that in the event of an emergency 911 will be contacted. (Dr. note may be required)

\_\_\_\_\_  
Parent Signature

### 4th Child Information

CHILD'S NAME \_\_\_\_\_ Nickname (If any) \_\_\_\_\_

Birth date \_\_\_\_\_ Age \_\_\_\_\_ Gender: M or F

School \_\_\_\_\_ Child's Grade as of Sept. 2025: \_\_\_\_\_ Classroom Teacher \_\_\_\_\_

Schedule—Circle one: AM PM BOTH or SHO PLUS\*

Days—Circle all that apply: M T W H F Desired Start Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

In order to provide your child with the best services possible please let us know, along with a brief description, if your child has any of the following conditions: (Please circle yes or no for each)

Yes or No Asthma\* \_\_\_\_\_

Yes or No Diagnosed Allergies\* \_\_\_\_\_

Yes or No Sensitivities or Intolerances \_\_\_\_\_

Yes or No Diabetes \_\_\_\_\_

Yes or No Epilepsy or Seizures \_\_\_\_\_

Yes or No Takes Regular Medication \_\_\_\_\_

Yes or No Allergic to Medications \_\_\_\_\_

Yes or No ADHD (list accommodations) \_\_\_\_\_

Yes or No Court/Custody Issues (if yes please attach a copy of court/custody papers)

*\*\*Court Orders must be provided to the BASCOL Office to legally prevent a parent from having access to and/or picking up a child\*\**

Yes or No Receives services at school (speech, OT, PT, etc.) has IEP, 504 plan, or behavior plan.\*\*\*

Please explain and attach copy of plan. \_\_\_\_\_

Yes or No Is your child able to successfully participate in a program with 1 adult per group of 10 children?

Yes or No Other (Please explain) \_\_\_\_\_

\*No medication needed while at BASCOL. I understand that in the event of an emergency 911 will be contacted. (Dr. note may be required)

\_\_\_\_\_  
Parent Signature