

ST. MICHAEL THE ARCHANGEL EXTENDED DAY PROGRAM
ENROLLMENT FORM KR-5th
2020-2021

Child's Name _____ Grade _____ Sex _____ Birthdate _____

2nd Child _____ Grade _____ Sex _____ Birthdate _____

3rd Child _____ Grade _____ Sex _____ Birthdate _____

Home Address _____ Phone _____

Email Address: _____

Mother's Name _____ Cell phone _____

Work Place Name _____ Work phone _____

Father's Name _____ Cell phone _____

Work Place Name _____ Work phone _____

****Please circle which number we should try first if needed – thank you****

In the event of an emergency, if parents cannot be reached, please contact:

<u>Name</u>	<u>Address</u>	<u>Phone</u>	<u>Relationship</u>
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1.

2.

PROGRAM USAGE: Mark which type of user you will be. Usage type can change with note to Director.

Weekly Set Schedule (mark days/times below)

Before School Only M T W TH F

After School Only M T W TH F

Weekly, days vary (send note/email to child's teacher AND ext day to attend)

As Needed (send note/email to child's teacher AND ext day to attend)

School delays/cancellations

Names of Authorized Persons for pick up: Student will ONLY be released to these names.

1. _____ Driver License # _____ Phone _____

2. _____ Driver License # _____ Phone _____

Additional information needed: (i.e. allergies, behavioral/emotional problems, likes/dislikes, etc.)

There is a MANDATORY KEY CARD FEE of \$8.00. If you need more than 1 key card (one for each parent), it is \$16.00. Please add this amount to the registration fee.

Registration fees: \$15.00 first child \$20.00 two children \$25.00 three or more

Please see reverse side: PART I OR II MUST BE COMPLETED

OFFICE USE ONLY:

Registration fee paid \$ _____ Date _____ Check Number _____ Staff Initials _____

Number of key cards issued _____ key card #'s:

Part I: TO GRANT CONSENT

Please complete both physicians and dentist portion.

I hereby give consent for the following medical care providers and local hospital to be called:

Physician _____ Phone _____

Address _____

Dentist _____ Phone _____

Address _____

Hospital _____ Phone _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for:

1. The administration of any treatment deemed necessary by above-named doctors, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist.
2. The transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

Signature of Parent/Guardian _____ Date _____

Address _____

PART II: REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment for my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

Signature of Parent/Guardian _____ Date _____

Address _____