

St. James School Extended Day Program Registration 2007-2008

Family Last Name: _____

Address: _____ City: _____ St: _____ Zip: _____

Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Children **Name** _____ Age ____ Grade ____ **Name** _____ Age ____ Grade ____
Name _____ Age ____ Grade ____ **Name** _____ Age ____ Grade ____

Check items that apply: We will be using the program () **Regular Basis** () **Occasional Basis**

Before School: () 7:00 – 8:10 a.m. () 7:30 – 8:10 a.m.

After School: () 3:00 – 4:30 p.m. () 3:00 – 5:00 p.m. () 3:00 – 5:30 p.m.

Early Dismissal (1:00 or 1:30 pm): () 1:00 – 5:30 p.m.

Occasional Enrollee

I will notify the office one day in advance whenever possible. The fee for the day will be billed.

Late Charge

I understand a late charge of \$1.00 for every 1 minute past 5:30 p.m. if I am late to pick up my children.

Fee

I understand that I must make regular payments on my Extended Care account. If I don't, the school will ask me not to participate in the program until all payments are made.

Forms:

I understand the this form must be completed and returned to the school office before my child(ren) can participate in the program.

EMERGENCY TREATMENT RELEASE

To Whom It May Concern:

As a parent and/or guardian, I do herewith authorize the treatment by a qualified and licensed medical doctor of the minor(s) on this form in the event of a medical emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed.

Name of Child's Physician _____ Phone:() _____

Name of Child's Dentist _____ Phone () _____

Please list allergies, chronic conditions, or health problems experienced by each child as well as any regular medications taken

NAME	Medications	Allergies	Chronic Conditions	Health Problems

Name of Medical Insurance Carrier _____

Insurance Carrier address _____

City _____ St _____ Zip Code _____ Phone _____

Group/Plan Number _____ Name of responsible party _____

List 2 or 3 other persons who may be contacted in the case of an emergency other than parents/guardians

NAME	Telephone	Relationship to children

The following persons, other than myself, are authorized to pick-up my child(ren). Please include spouse if applicable.

NAME	Telephone	Relationship to children

I have received and read the Extended Care Program Policy Handbook. I have discussed the pertinent sections with my children and agree to support the provisions and regulations contained therein. I have completed the back side of this form with emergency information. I understand that my child will only be released to someone with prior authorization. If someone other than those persons listed above will be picking up my child, I will inform the Extended Care Program in writing. I understand NO telephone requests of this nature will be honored.

Parent/Guardian Signature

Date