ST. THOMAS THE APOSTLE SCHOOL EXTENDED CARE PROGRAM
REGISTRATION FORM/EMERGENCY FORM

Child's
Name:_____ Grade_____ Age _____DOB_____
Address:_____
Parent's Name_____Phone_____Cell_____
_____Phone_____Cell_____
E-Mail Address:_____
Father's Place of
Employment_____Phone_____
Mother's Place of
Employment_____Phone_____

Emergency Contact Person:_____Phone_____Cell_____
Family Doctor_____Phone_____
Hospital Preferred_____Phone_____
List any medical problems, medication, allergies, etc.,_____

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_____ My child or children will attend Extended Care full-time.

_____ My child or children will attend Extended Care part-time on _____days only.

_____ My child or children will attend Extended Care only when needed.

Name of Persons authorized to pick up your child:

1. _____Phone_____Cell_____
2. _____Phone_____Cell_____
3. _____Phone_____Cell_____

Approximate time your child will be picked up _____.

I,_____, hereby authorize St. Thomas Extended Care Program to seek emergency medical assistance for my child/children, _____ _____ in case of an accident and I cannot be reached.

Signature_____

Return completed form to the office before the first day of admission. Thank you!