

**2010-2011**  
**St. John the Baptist School**  
**After School Care Program Registration Form**  
**After School Care Phone 583-2392 Ext. 23**

Family's Last Name: \_\_\_\_\_

Child's First Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_

Child's First Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_

Child's First Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_

Registering for: Full Time: (4-5 days/week) \_\_\_\_\_

Part Time: (1-3 days/week) \_\_\_\_\_

(or) Occasional Day of Emergency Care: \_\_\_\_\_

Approximate time that your child/children will be picked up each evening: \_\_\_\_\_

Identification Information:

Home Phone #: \_\_\_\_\_

Home Address:

\_\_\_\_\_

Mother's Name: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

Pager #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

Mother's Place of Employment: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

Pager #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

Father's Place of Employment: \_\_\_\_\_

Emergency Information:

Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

After Hours Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Emergency contact person (other than parent or doctor):

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Relationship: \_\_\_\_\_

Work/Other #: \_\_\_\_\_

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Relationship: \_\_\_\_\_

Work/Other #: \_\_\_\_\_

Please list any medical conditions that the Care Coordinator should be aware of: (food allergies, medication allergies, bee sting allergy, medical conditions—asthma/diabetic).

Child's Name: \_\_\_\_\_  
Conditions: \_\_\_\_\_

Child's Name: \_\_\_\_\_  
Conditions: \_\_\_\_\_

Child's Name: \_\_\_\_\_  
Conditions: \_\_\_\_\_

*If a child becomes ill while at After School Care, the parent will be notified and that child will be separated from the rest of the children to keep exposure to a minimum.*

*In case of an accident or serious illness, if we or the people designated are unable to be reached, I hereby authorize the Care Coordinator to call the physician listed above and to follow their instructions. If the physician is unable to be contacted, the Care Coordinator or person in charge may make whatever arrangements are deemed necessary.*

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<i>Parent/Guardian Signature</i>	<i>Print Name</i>	<i>Date</i>
<i>Please allow</i> _____		<i>Please allow</i> _____

<i>To leave school at (time)</i> _____	<i>to leave school at (time)</i> _____
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<i>Because</i> _____	<i>because</i> _____
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<i>He/she (will – will not) return.</i>	<i>He/she (will – will not ) return.</i>
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<i>Date</i>	<i>Parent Signature</i>	<i>Date</i>	<i>Parent Signature</i>
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