St. John the Baptist School
Before School Care Program Registration Form
Time: 6:30 – 7:30 a.m. / Cost: $2.00 per child

Parents' Names: _____

Child's Name: _____ M / F: _____ Grade: _____ DOB: _____
Child's Name: _____ M / F: _____ Grade: _____ DOB: _____
Child's Name: _____ M / F: _____ Grade: _____ DOB: _____
Child's Name: _____ M / F: _____ 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 arrive: _____

Identification Information:

Mother: _____ Father: _____

Cell Phone Number: _____ Cell Phone Number: _____

Work Phone Number: _____ Work Phone Number: _____

Home Address: _____

Emergency Information:

Physician: _____ Phone #: _____
After Hours Phone #: _____

Address: _____

Please list any medical conditions that the Care Coordinator should be aware of: (allergies, medical conditions)

Child's Name: _____ Medical Condition: _____
Child's Name: _____ Medical Condition: _____
Child's Name: _____ Medical Condition: _____
Child's Name: _____ Medical Condition: _____

If a child becomes ill while at Before 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.

_____

Parent/Guardian Signature *Print Name* *Date*