

**ST. MICHAEL THE ARCHANGEL EXTENDED DAY PROGRAM  
ENROLLMENT FORM K-5<sup>th</sup>  
2017-2018**

Child's Name \_\_\_\_\_ Grade \_\_\_\_\_ Sex \_\_\_\_\_ Birthdate \_\_\_\_\_

2<sup>nd</sup> Child \_\_\_\_\_ Grade \_\_\_\_\_ Sex \_\_\_\_\_ Birthdate \_\_\_\_\_

3<sup>rd</sup> Child \_\_\_\_\_ Grade \_\_\_\_\_ Sex \_\_\_\_\_ Birthdate \_\_\_\_\_

4<sup>th</sup> 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>
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.)

\_\_\_\_\_  
\_\_\_\_\_

**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 \_\_\_\_\_

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 deem necessary by above-named doctors, or in the event the designated preferred practioner 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 \_\_\_\_\_