**ST. MICHAEL THE ARCHANGEL EXTENDED DAY PROGRAM**
**ENROLLMENT FORM K-5th**
**2016-2017**

Child's Name_____Grade_____Sex_____Birthdate_____

2nd Child_____Grade_____Sex_____Birthdate_____

3rd Child_____ Grade_____Sex_____Birthdate_____

4th 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:

| Name | Address | Phone | Relationship |
|---|---|---|---|
| 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_____