St. Ann Catholic School
Before/After Care Program Registration

Name:_____ Date of Birth:_____ Grade:____

Address:_____
(Street) (City) (Zip) (Phone)

REGISTRATION FOR:
_____Before Care _____After Care
BILLING INFORMATION
_____ Monthly _____Hourly

Male Head of Household

Name:_____
Place of Work_____
Work Phone:_____Ext._____
Cell Phone:_____

Female Head of Household

Name:_____
Place of Work_____
Work Phone:_____Ext._____
Cell Phone:_____

EMERGENCY INFORMATION
RELATIVE OR FRIENDS to contact if we cannot reach you (local only)
Please be sure the persons you name here are aware that you have indicated that they will be called in an emergency.

Name:_____ Relationship_____
Address:_____ Phone:_____

Name:_____ Relationship_____
Address:_____ Phone:_____

Hospital of Choice_____ Phone:_____
Doctor:_____ Phone:_____
Dentist:_____ Phone:_____

Authorized Adults (other than parent) allowed to pick up student:
Name:_____ Phone:_____
Name:_____ Phone:_____

Adults child **CANNOT** be released to:_____
_____

Special Health Problems: Please list here any special conditions such as asthma, excessive bleeding, diabetes, or any other condition. Indicate exact instructions for the care of your child.

_____
_____

Allergies: Please indicate any allergies your child might have and the exact treatment.
Medicines:_____ Treatment:_____
Insect Bites or Stings:_____ Treatment:_____
Other – be specific:_____ Treatment:_____

I hereby give my permission for the child named above to receive first aid treatment for illness or injuries as specified above, and/or to be taken to the hospital by ambulance if immediate treatment is necessary. I agree to pay for all medical expenses thus occurred.

PARENT/GUARDIAN SIGNATURE:_____**DATE**_____