ST. JOSEPH SCHOOL
320 W. Stephen Foster Ave.
Bardstown, Ky 40004
502-348-5994

EXTENDED CARE REGISTRATION FORM

A **$25.00** NON-REFUNDABLE REGISTRATION FEE PER FAMILY IS DUE AT TIME OF REGISTRATION. NO REGISTRATION WILL BE ACCEPTED IF INFORMATION IS INCOMPLETE.

CHILD'S NAME	BIRTHDATE	GRADE
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Parent(s) or Guardian(s) with whom child/children resides:_____

Address:_____

Father's name:_____ Home phone:_____

Address:_____ Cell phone:_____

Employer:_____ Work phone:_____

Email address:_____

Mother's name:_____ Home phone:_____

Address:_____ Cell phone:_____

Employer:_____ Work phone:_____

Email address:_____

Names of persons, other than parents, authorized to pick up your child/children:

Name	Relationship	Home phone	Work/Cell phone
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

ANY CHANGES OF AUTHORIZED PERSONS MUST BE MADE IN WRITING BY PARENT OR GUARDIAN.

_____ I give St. Joseph Extended Care permission to take my child to the gym/playground on days when it available to the child care.

I have read, understand and agree to all policies in the St. Joseph Extended Care Handbook. I am responsible for paying all fees for my child/children on time or $10.00 late fee will be assessed. I understand and agree with the policy that nonpayment will result in my child/children being withdrawn from St. Joseph Extended Care.

SIGNATURE_____ DATE _____

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MEDICAL/EMERGENCY INFORMATION

All children must have medical insurance to be enrolled. An updated immunization certificate must be sent to the office.

Child/Children's Physician _____ Phone_____

Hospital _____ Phone_____

Insurance _____ Group # _____

Policy # _____

Health limitations _____

Medical allergies _____

Food allergies _____

List the names of 3 persons we may notified in case of emergency of illness in the event that a parent/guardian cannot be reached.

	Name	Relationship	Home phone	Work/Cell phone
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

If a medical emergency arises, we will attempt to contact a parent/guardian. If one cannot be reached, we will call the names listed in the above order. In the event a responsible adult cannot be reached, will call the listed physician and follow his or her orders.

I REQUEST AND AUTHORIZED THE CHILD CARE DIRECTOR AND/OR STAFF TO ACT ON MY BEHALF IN ADMINISTERING FIRST AID UNTIL A PARENT OR RESPONSIBLE PARTY CAN BE LOCATED AND MAY CONTACT MY CHILD'S PHYSICIAN OR EMS IN THE EVENT OF AN EMERGNCY.

SIGNATURE_____ DATE_____

IF YOU AND THE PHYSICIAN OF YOUR CHOICE AS INDICATED CANNOT BE REACHED IN AN EMERGENCY AND, IF IN THE JUDGEMENT OF THE STAFF, IMMEDIATE MEDICAL AND/OR HOSPITAL ATTENTION IS INDICTED, I AUTHORIZE THE ST. JOSEPH STAFF TO SEND MY CHILD (PROPERLY ACCOMPANIED) TO THE HOPITAL LISTED ABOVE. I RELEASE THE CHILD CARE STAFF AND ST. JOSEPH SCHOOL AND PARISH OF ANY LIABILITY INVOLVED IN ACTING IN A REASONABLE AND RESPONSIBLE MANNER.

SIGNATURE_____ DATE _____