St. John the Apostle Catholic School

Extended Day Care Program

EMERGENCY INFORMATION:

Child's Name ______________ Date of Birth: ________ Home Tel. #: __________

Address: ______________ Grade: ________ Teacher: __________

Mother: ______________ Cell# ________ Work #: __________

Mother's Place of Work: ______________________________

Father : ______________ Cell#: ________ Work #: __________

Father's Place of Work: ______________________________

SPECIAL MEDICAL CONCERNS: ______________________________

ALLERGIES: ______________ MEDICATION: ______________

Will we need to administer medication? Yes / No (please circle)

CONFIDENTIAL:

Is there any special custody, legal and/or physical custody arrangements that we should be aware of?______________________________

____

EMERGENCY CONTACT: (If we are unable to reach you) Will this person also be able to "pickup" your child if you are unable to? If so PICTURE I.D. MUST BE SHOWN! No child will be released unless proof of identity is shown –NO EXCEPTIONS!)

1. Name: __________ Cell# __________ Home# __________ Work# __________

Address: ______________________________

2. Name: __________ Cell# __________ Home# __________ Work# __________

Address: ______________________________

3. Name: __________ Cell# __________ Home# __________ Work# __________

Address: ______________________________

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DROP-OFF AND PICK-UP INFORMATION

Child's Name Teacher: ________ Grade: ________ Home # ________

FOOD ALLERGIES: ________________________

Siblings in school: ________ Name(s) and Grade: ________________

____

____

MORNING CARE:

DAYS ATTENDING: ________________________

Who will drop off? (Is this info also on file?)

Name: ________ Work ________ Home# ________

SJA CAR POOL? ________ SJA Driver Family Name: ________

AFTER – CARE:

DAYS ATTENDING: ________________________

Who will pick-up child?_ (Is this info on file with Extended Care? (Picture I. D. needed!)

Name ________ Cell# ________ Work# ________ Home# ________

SJA CAR POOL? ________ SJA Driver Family Name: ________

SPECIAL INFORMATION we need to be aware of? ________________

____

EXTENDED CARE MEDICAL FORM

Please provide the following information pertaining to each child:

Child's Name_______________________________ Age: ________ Grade: _____

Address: ____

Mother's Name: _____________________

Phone #: (H) ____________________ (W) ____________________ (C) _____________

Father's Name ____________________________

Phone #: (H) ___________________ (W) _____________________(C) ______________

Known Allergies (food or medication) ____

Medication currently taking: ____

Pediatrician's Name and Phone # ____

Dentist's Name and Phone # ____

IN THE EVENT MY CHILD SHOULD BECOME ILL DURING EXTENDED CARE, I WILL BE NOTIFIED OF MY CHILDS CONDITION AND I AGREE TO PICK MY CHILD UP IF REQUIRED.

Parent Signature: __________________________________ Date: __________________