St. Augustin PK, TK and K-8 Extended Care
4320 Grand Avenue
Des Moines, IA 50312
2023-2024

COMPLETE ONE FORM FOR EACH CHILD

Please list children's food allergies, if any:______________________________

Child's Name ______________________ Age_____ Birthdate__________ Grade______ Sex_________

CARE DESIRED: Before Care_____________ After Care____________ Before & After Care______________

Mother's Name ______________________________ Home Phone ____________________

Address ______________________________ Cell Phone ____________________

Employer ______________________________ Work Phone ____________________

Email Address______________________________

Father's Name ______________________________ Home Phone ____________________

Address ______________________________ Cell Phone ____________________

Employer ______________________________ Work Phone ____________________

Email Address______________________________

Emergency Information:
In the event that my child may require emergency medical, dental, or surgical care while I am unable to be reached, I hereby give my consent to medical, dental, or surgical treatment to:

Doctor/Clinic Name ____________________ Address____________________ Phone ________________

Hospital (circle one) – Broadlawns Mercy West Mercy (Downtown) Mercy West Lakes (60th) Lutheran

Methodist (Downtown) Methodist West (60th) Blank Children's Hospital

Dentist Name ______________________________ Phone ____________________

Dentist Address ____
I agree to pay all the costs and fees contingent on emergency care or treatment for my child as secured or authorized under this consent.

In an emergency please call: (in case parents are unreachable)

Name/Relation: ______________________________ Phone ______________ Cell ______________

Name/Relation: ______________________________ Phone ______________ Cell ______________

Pick Up Permission- Please circle yes or no for the following:

Yes / No I hereby give permission for my child to leave the center for fieldtrips in a vehicle provided by the center, or on foot. I give permission for my child to be transported to and from school in the vehicle provided by the center. A childcare employee will transport my child to and from school in a center provided vehicle.

Yes / No I hereby give permission for my child to leave the center with the following persons named below. It is the responsibility of the parent to notify the center, in writing, of any changes.
Name______________________________ Relationship______________________________
Name______________________________ Relationship______________________________

Yes / No I grant center staff the right to take photographs of my child engaged in center activities to be displayed within the center.

Names of persons who may not pick up the child:____
Separation, divorce, or other custody situations the center should be aware of:______________________________
____

______________________________ ______________
Parent/Guardian Signature Date

Immunization and physical forms available in the school office and electronically.

St. Augustin Before / After Care Program
Emergency Medical Authorization

(Form must be returned by the first day of attending Before/Aftercare.)

I, ____________________________________, mother/father/guardian of
______________________________________, age _____, grade _____,

do hereby give my permission and/or consent to St. Augustin School Before/After Care Program to secure and authorize such emergency medical care and/or treatment as my child named above might require while under the supervision of St. Augustin School Before/After Care Program. I also agree to pay all costs and fees contingent on any emergency medical care and/or treatment for my child as secured or authorized under this consent.

NOTE: Every effort will be made to notify parents/guardians IMMEDIATELY in case of emergency. In the event of an emergency, it would be necessary to have the following information.

Name of Physician to contact:_______________________________

Physician's Phone #:_______________________________________

Name of Hospital:____

I agree to this authorization for the period of time that my child attends St. Augustin School Before/After Care Program and will inform the school as to any change in name of physician or hospital.

_______________________________________ ________________________

Signature of Parent/Step-Parent/Guardian Date