

St. Augustin PreK & Opt K AfterCare Program

Student Information Form

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

Child's Name _____
Child's Birthdate _____ Age _____ Sex _____

MOTHER'S NAME _____
Mother's Home Address _____
Mother's Place of Employment _____
Employment Address _____
Mother's Phone _____ (Main) _____ (Work)

FATHER'S NAME _____
Father's Home Address _____
Father's Place of Employment _____
Employment Address _____
Father's Phone _____ (Main) _____ (Work)

EMERGENCY INFORMATION:

In the event that my child requires 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: _____ Phone: _____
Doctor/Clinic Address: _____
Hospital: Broadlawns Mercy West (60th) Mercy (DT)
 Blank Children's Hospital Other: _____

Dentist Name _____ Phone: _____
Dentist Address: _____

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

Please list childrens food allergies, if any:

EMERGENCY INFORMATION

In an **emergency** please call: (If parents are unreachable)

Name/Relationship _____ Main phone/s _____

Name/Relationship _____ Main phone/s _____

PERMISSION: Only the following adults may pick up my child/ren from St. Augustin After Care. I will notify the Director or school office whenever this will occur.

Names of persons who **may not** up the child/ren: _____

Separation, divorce or other custody situation the Director should be aware of:

Signature of Parent/Step-Parent/Guardian

Date

St. Augustin 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 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 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 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

**St. Augustin After Care Program
Change of Information**

Child(ren)'s Name(s)

Please change the information on my child(ren)'s registration and emergency forms to the following:

Child(ren)'s Address _____
City _____ Zip _____ Phone _____

Parent/Step-Parent/Guardian:

Address _____ City _____
_____ Zip _____ Phone _____

Place of Employment _____ Phone _____

Place of Employment _____ Phone _____

Other _____

Signature of Parent/Step-Parent/Guardian

Date

Please return this form to St. Augustin After Care Program.
Thank you.

St. Augustin After Care Program
Addition To or Change of Pick-Up Authorization

Child(ren)'s Name(s)

Please **add** the following to my child(ren)'s registration and emergency forms. These adults are authorized to pick up my child(ren) at Before/After Care.

Name _____
Relationship _____ Phone _____

Name _____
Relationship _____ Phone _____

Name _____
Relationship _____ Phone _____

Please **remove** the following name(s) from my child(ren)'s registration and emergency forms. Those listed are no longer authorized to pick up my child(ren) at After Care.

Name _____
Name _____
Name _____

Signature of Parent/Step-Parent/Guardian

Date

Please return this form to St. Augustin Before/After Care Program.
Thank you.

**St. Augustin After Care Program
Discontinuance of Service**

Child(ren)'s Name(s)

My child(ren) named above will no longer be attending St. Augustin After Care Program as of _____.
(date)

Signature of Parent/Step-Parent/Guardian

Date

Please return this form to St. Augustin After Care Program.
Thank you.