EXTENDED CARE

Registration Form

Student/Students Information

FIRST NAME	LAST NAME	DATE OF BIRTH (DD/MM/YYYY)	GRADE

Parent Information

MOTHER

FIRST NAME	LAST NAME	CELL PHONE

FATHER

FIRST NAME	LAST NAME	CELL PHONE

PLEASE CHOOSE THE EXTENDED CARE OPTION THAT WORKS BEST FOR YOUR FAMILY (PLEASE CHOOSE 1).

I WOULD LIKE MY CHILD(REN) TO ENROLL IN:

- ☐ FULL-TIME MORNING CARE (K-8)
- ☐ DROP IN MORNING CARE
- ☐ FULL-TIME AFTERCARE
- ☐ DROP IN AFTERCARE

PLEASE INITIAL THE FOLLOWING STATEMENTS:

- ☐ I UNDERSTAND THAT ST. EDWARD EXTENDED CARE PROGRAM WILL USE THE FACTS SYSTEM FOR THE FOLLOWING INFORMATION: PARENT CONTACT, EMERGENCY CONTACT AND PICK UP RELEASE, ALLERGY INFORMATION, MEDICAL CONDITIONS, AND PERMISSION TO TREAT IN CASE OF AN EMERGENCY.
- ☐ I HAVE READ AND UNDERSTAND THE POLICIES OF THE ST. EDWARD EXTENDED CARE PROGRAM.
- ☐ THE STATE OF TENNESSEE DEPARTMENT OF EDUCATION SUMMARY OF CHILD CARE APPROVAL HAS BEEN MADE AVAILABLE TO READ.
- ☐ IN CASE OF ACCIDENT OR SERIOUS ILLNESS, I REQUEST THE STAFF TO CONTACT ME. IF THE STAFF IS UNABLE TO REACH ME, I HEREBY AUTHORIZE THE STAFF TO CALL THE PHYSICIAN INDICATED ABOVE AND TO FOLLOW HIS OR HER INSTRUCTIONS. IF IT IS IMPOSSIBLE TO CONTACT THIS PHYSICIAN, THE AFTER-SCHOOL PROGRAM/SUMMER CARE MAY MAKE WHATEVER ARRANGEMENTS DEEMED NECESSARY FOR THE SAFETY OF MY CHILD.

NAME	SIGNATURE	DATE