ST. PATRICK'S ELEMENTARY SCHOOL

After-School Care Program
Application Form

Start date: _____

Child's Full Name: _____

Gender: ☐ Male ☐ Female

Birthday: _____

Address: _____

Home Phone Number: _____

Mother's Name: _____ Cell Number: _____ Home:_____

Father's Name: _____ Cell Number: _____ Home:_____

Official Tax Receipt Payable to: _____

REGISTRATION REQUIREMENTS FEE: ☐ $30.00 Non-refundable

PLEASE CHECK YOUR PROGRAM PREFERENCE:

5 DAYS A WEEK:	☐
4 DAYS A WEEK:	☐
3 DAYS A WEEK:	☐
2 DAYS A WEEK:	☐
1 DAY A WEEK:	☐
DROP IN ONLY:	☐

OFFICE USE ONLY	
Tuition Rate:	
Date:	
Received By:	