Registration $40.00 per family and will be billed through Facts Management.

Saint Joseph Summer Care Registration

20____

Child's Name	Boy	Girl	Date of Birth	Grade

Address ____

Phone ____________________ Cell ____________________ Work ____________________

Alternate Phone Number ____________________________

Parent Email ____

Please list any allergies, medical needs, special instructions, or other information the staff needs to be aware of in the care of your child.

____

____

____

In the event of apparently serious illness or accident, when I cannot be reached, I wish one of the following to be notified. They are authorized to act in my absence. They may also release my child from the Extended Day Program.

Name/Relationship to Child   Address   Phone

____

____

____

The following MAY NOT CALL for my child. ______________________________

EMERGENCY MEDICAL AUTHORIZATION

School: Saint Joseph School

Date ______________

Student Name ______________

Address ______________

Grade ______________ City, State, Zip ______________

Home Phone ______________

Purpose- To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

esidential Parent or Guardian

Mother's Name ______________ First ______________ Last Daytime Phone ______________

Father's Name ______________ First ______________ Last Daytime Phone ______________

Other's Name ______________ First ______________ Last Daytime Phone ______________

ame of Relative or Childcare Provider

______________ Relationship ______________

ddress ______________ Daytime Phone ______________

ity, St, Zip ______________

PART 1 OR 2 MUST BE COMPLETED

ART 1: TO GRANT CONSENT ☐ Part 1 Consent Given ☐ Part 2 Consent Refused

hysician ______________ Phone ______________

entist ______________ Phone ______________

ledical Specialist ______________ Phone ______________

ocal Hospital ______________ ER Phone ______________

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-names doctors, or, in the event the designated preferred practitioner is not available, by any other licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

Parent Signature ______________

Address ______________

City, State, Zip ______________ Date ______________

ART 2: REFUSAL TO CONSENT

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

____

Parent Signature ______________

Address ______________

City, State, Zip ______________ Date ______________

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