

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 \_\_\_\_\_

Grade \_\_\_\_\_

Student Name \_\_\_\_\_

Address \_\_\_\_\_

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.

## Residential Parent or Guardian

Mother's Name \_\_\_\_\_

Daytime Phone \_\_\_\_\_

Father's Name \_\_\_\_\_

Daytime Phone \_\_\_\_\_

Other's Name \_\_\_\_\_

Daytime Phone \_\_\_\_\_

## Name of Relative or Childcare Provider

Address \_\_\_\_\_

Relationship \_\_\_\_\_

City, St, Zip \_\_\_\_\_

Daytime Phone \_\_\_\_\_

## PART 1 OR 2 MUST BE COMPLETED

## PART 1: TO GRANT CONSENT

 Part 1 Consent Given  Part 2 Consent Refused

Physician \_\_\_\_\_

Phone \_\_\_\_\_

Dentist \_\_\_\_\_

Phone \_\_\_\_\_

Medical Specialist \_\_\_\_\_

Phone \_\_\_\_\_

Local 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 \_\_\_\_\_

## PART 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 \_\_\_\_\_