St. Joseph Day School Extended Day
2023-2024

175 St. Joseph Drive
Amherst, Ohio 44001
Phone: (440)665-8378 or (440)988-4244

Email: extended.preschool@sjs-amherst.org

Hours: 2:15 pm - 6:00 pm

2:15-3:00 $7.00
3:01-3:30 $9.50
3:31-4:00 $12.00
4:01-4:30 $14.50
4:31-5:00 $17.00
5:01-5:30 $19.50
5:31-6:00 $22.00
6:01 and on
Is considered a late pick-up and will be charged an additional $6.00 every ten minutes.

A multiple child discount is available. For each additional child that attends on the same day as a sibling(s), the cost will be $6.00 for care on that day for each additional child.

*Please note that fees for the Extended Day After School Program are billed separately from the Extended Day Preschool Program.

Registration Fee
$50.00 per family

Registration$50.00 per family and will be billed through Facts Management.

Saint Joseph Extended Day Registration

20___-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.

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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.

Residential Parent or Guardian

Mother's Name ____________ (First) ____________ (Last) Daytime Phone ____________

Father's Name ____________ (First) ____________ (Last) Daytime Phone ____________

Other's Name ____________ (First) ____________ (Last) Daytime Phone ____________

Name of Relative or Childcare Provider

____________ Relationship ____________

Address ____________ Daytime Phone ____________

City, St, Zip ____________

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 ____________