ST. PATRICK SCHOOL
MORNING/AFTER SCHOOL CARE PROGRAM
Rev. AUGUST 2025
CONTACT & EMERGENCY INFORMATION

Child # 1 :_____ Grade:_____ Age: _____ Sex:_____ Birth Date:_____

Address:_____

Child #2:_____ Grade: _____ Age: _____ Sex:_____ Birth Date:_____

Address: _____

CHECK ONE OPTION:

*Based on 10-Month SY August 2025

☐ **Morning Care Only $100.00** ☐ **After School Care Only $250.00**

☐ **Morning & After School $325.00** ☐ **Daily Drop in Rate Only $40.00**

Mother's Name:_____ Bus. Phone:_____

Address:_____ Home Phone: _____

Father's Name:_____ Bus. Phone:_____

Address:_____ Home Phone: _____

Guardian's Name:_____ Bus. Phone:_____

Address:_____ Home Phone: _____

1. Signing this agreement: A child may not enter the Morning Care/After School Care Program unless this registration agreement is signed by the parent(s) or guardian(s) legally responsible for the child(ren).
2. Tuition Payment, Suspension, Withdrawal, Attendance & Late Pick-Up: Please refer to the St. Patrick After School Care Handbook.
3. Late Pick-Up: There is a late pick-up charge of $1.00 for each minute or fraction thereof after 5:30p.m. Late Pick-Up fees will be added to your school billing statement.

EMERGENCY INFORMATION **(PLEASE FILL IN ALL INFORMATION BELOW)**

It is the policy of St Patrick School to contact the parents of the students regarding medical treatment if the student is seriously injured or becomes ill. Students are taken to the nearest emergency facility. In case of an emergency, list person(s) to be contacted IF PARENTS CANNOT BE REACHED.

Name _____ Phone _____ Relationship_____

Address _____ City/State/Zip Code _____

Name _____ Phone _____ Relationship_____

Address _____ City/State/Zip Code _____

If parents or person listed above cannot be reached, I give permission for St. Patrick School to call the physician below and to follow the physician's instructions.

Physician's Name _____ Phone _____

Address _____ City/State/Zip Code _____

PERMISSION & CONSENT List anyone who may pick up your child(ren) **excluding parents.** No child will be released to anyone not on this list. Authorized persons must be 16 years or older.

Name _____ Relation _____ Home Phone _____ Bus. Phone_____

Address _____ City/State/Zip Code _____

Name _____ Relation _____ Home Phone _____ Bus. Phone_____

Address _____ City/State/Zip Code _____

ALLERIES: LIST ALL ALLERGIES DOCUMENTED WITH A DOCTOR'S NOTE.

I (We) have read the After School Care Handbook and the terms. I (We) agree to abide by these rules and terms.

Mother/Guardian's Signature _____ Date _____

Father/Guardian's Signature _____ Date _____