St. Joseph Catholic School
After School Care (ASC) Registration Form
2020-2021

Student's Name: Last: ______________________________ First: _____________________________________

Grade: __________________ Date of Birth: _______________________ Age: ___________________________

Home Phone: _____________________________Address: ____

Mother/Guardian Name: ______________________________ Cell Phone: ________________________

Place of Employment: ________________________________ Work Phone: _______________________

Father/Guardian Name:_______________________________ Cell Phone:_________________________ Place of Employment: ________________________________ Work Phone: _______________________

Emergency Contacts: When I cannot be reached, please contact the following person(s). They have permission to pick up/make emergency decisions for my child.

1. Name: _______________________________________ Relationship to student: _____________________
   Work Number: _______________________________ Cell Phone:________________________________
2. Name: _______________________________________Relationship to student: ____________________
   Work Number: ______________________________ Cell Phone:________________________________
3. Name: _______________________________________Relationship to student: ____________________
   Work Number: ________________________________ Cell Phone:______________________________

Doctor's Name: _______________________________________ Phone: __________________________________

Insurance Provider: ____________________________________Policy Number: ___________________________

Allergies or Medical Conditions: ____

Medications Needed:____

Please anyone that **DOES NOT** have permission to pick up your child: ___________________________________

- Billing Preference form (attached) must be filled out and returned in order for your child to attend the program.
- ASC **WILL NOT** be available on days that the school is closed or on early release days.

Agreement and Release Form

I hereby release St. Joseph Catholic School/Church and the Catholic Diocese of Austin and their representatives from any liability, loss, damage, costs, claims, and/or causes of action, including but not limited to all bodily injuries and property damage arising from my child _________________________________ participating in the After School Care Program. I further give permission for the Director and/or staff of the St. Joseph Catholic School After School Care Program to authorize medical treatment on my behalf in the event of a medical emergency when I cannot be reached.

I understand every effort will be made to contact me, or the emergency contacts I have listed above, should an emergency arise. I understand there is a late fee if my child is not picked up on time and a drop in fee if my child uses the services of the After School Care Program on an as needed basis.

Signature of Parent/Guardian: ______________________________________ Date: _______________________

St. Joseph Catholic School
After School Care
Billing Preference
2020-2021

Students Enrolled in the After School Care Program:

• Student 1 – Name: ____ _Grade: ____________________

• Student 2 – Name: ____Grade: _____________________

• Student 3 – Name: ____Grade: _____________________

Parent/Guardian Name: ____________________________________Cell Phone: ____________________________

Home Phone: ____Work Phone: ___________________________

Permanent Address:

____

Person responsible for ASC charges:

Parent/Guardian Name: ____ Cell Phone: _____________________

Home Phone: ____ Work Phone: ____________________________

Mailing Address for Billing:

____

I wished to be billed:

_____ I will sign up on FACTS for an annual plan of $720 per year per child

_____one payment due August 19, 2020 of $720.00 each per child

_____ two payments due on August 19, 2020 and January 5, 2021 of $360.00 each per child

_____I will sign up on FACTS for a monthly plan of $80 per month per child to be paid in 9 payments beginning with my September FACTS payment

Drop In Use:

_____ I wish to pay as a drop-in whenever my child uses the ASC program, I will pay the elementary school Administrative office $15 per day when I use the service.

Agreement

I, ____, understand that payments for the After School Program are in addition to the monthly tuition and must be paid through FACTS. I agree to inform the school in writing using this form if my child stops attending the ASC program or I wish to change my billing preference. Until such time, I understand that I will be billed according to my preferences noted above.

Signature of Parent/Guardian: _______________________________________ Date: _________________________