

# *Immaculate Heart of Mary School*

## Morning Drop-Off Registration

Rate: \$10 per child, per day in attendance

Please complete both sides of this document and submit it to the IHM school office. Attendance in this program is prohibited without prior registration. The morning drop-off begins Tuesday, September 14th, 2021.

<u>Child(ren's Name</u>	<u>Grade</u>
_____	_____
_____	_____
_____	_____

### Medical Conditions/Allergy Information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Mother's Cell #: \_\_\_\_\_ Mother's Work #: \_\_\_\_\_

Mother's Email: \_\_\_\_\_

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

Father's Cell #: \_\_\_\_\_ Father's Work #: \_\_\_\_\_

Father's Email: \_\_\_\_\_

**PLEASE COMPLETE BOTH PAGES OF THIS APPLICATION AND SIGN WHERE INDICATED. (OVER**

**In case of emergency, the following person(s) will be contacted if you are unreachable.**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Cell #:** \_\_\_\_\_ **Home #:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Cell #:** \_\_\_\_\_ **Home #:** \_\_\_\_\_

**Physician Information**

**Physician's Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Physician's Office Address:** \_\_\_\_\_

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_