Maternity B.V.M. School
CARES Program - Application Form

Child's/Children's Name:	**Sex- M/F**	**Date of birth**	**Grade in Sept 2019**

Address:

Street *City* *Zip* *Home Telephone*

Parent/Guardian Information:

Mother's Name *Employer/Address* *Daytime Telephone*

Father's Name *Employer/Address* *Daytime Telephone*

Guardian / Relationship *Employer/Address* *Daytime Telephone*

Emergency Information:

In the event of serious illness or accident when I cannot be reached, I wish one of the following to be notified by telephone. They are authorized to act in my absence.

Name *Address* *Telephone*

Name *Address* *Telephone*

If one of the above cannot be reached, I wish my child to be taken to the **Emergency Hospital**.

_____ YES _____ NO

Doctor's Name: _____ Telephone Number: _____

Special Instructions, Allergies?

Pick-up Time: _____ Early, by 4:30 PM _____ Late, by 5:45 PM

Names and Relationship of those who are authorized to pick up your child/children:

Non-refundable Registration Fee: $15.00 per family. Cash_____ Check #_____

NO CHILD WILL BE ADMITTED TO THE CARES PROGRAM UNTIL ALL THE NECESSARY FORMS HAVE BEEN COMPLETED AND RETURNED.

Signature of person who completed this form: _____

Relationship to student(s): _____ **Date:**_____