PREK 3 YEARS OLD THROUGH 8TH GRADE ($150.00/Month PER STUDENT) **8/13/20**

BISHOP LOUIS REICHER CATHOLIC SCHOOL ~ AFTER-SCHOOL CARE PROGRAM 2020-2021

Student's Name: _____ Grade: _____

Date: _____ _____
Signature of Father, Mother / Legal Guardian

Address: _____

City: _____ State: _____ Zip Code: _____

Childs Date of Birth: _____

Telephone # where parents, guardians or approved caregivers may be reached.

1._____ (Work) _____ (Cell) _____
Print name of Father or Guardian

2._____ (Work) _____ (Cell) _____
Print name of Mother or Guardian

3. _____ (Work) _____ (Cell) _____
Print name of Relative or Friend

OTHER PEOPLE WHO MAY PICK UP CHILD:

_____ (WORK) _____ (CELL) _____

_____ (WORK) _____ (CELL) _____

***ESTIMATED TIME OF PICK UP: _____**

ALLERGIES OR OTHER MEDICAL INFORMATION:

_____
_____
_____
_____

AUTHORIZATION FOR TREATMENT

(We), the guardian(s) of (Child's Name) _____
a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by , and is to be rendered by a physician on the medical staff of any accredited hospital, whether such diagnosis or treatment is rendered at the office of the physician or at the hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but it is given to provide authority and power on the part of the "Bearer" to give specific consent to any and all such diagnosis, treatment or hospital care which the physician in the exercise of his judgment may deem advisable.

Parent's Signature/Legal Guardian: _____

(We), the guardian(s) of (Child's Name) _____,

A minor, acknowledge that we have read and accept all the terms of the After School Care handbook, including additions for COVID-19 safety protocols for this school year.

Parent's Signature/Legal Guardian: _____