QUEEN OF ANGELS SCHOOL—EXTENDED CARE PROGRAM
(260-483-8214 Extension 8008)

REGISTRATION / EMERGENCY INFORMATION

2015-2016

Custodial Parents' Name _____
Last First Middle

_____
Last First Middle

Address _____
Street City Zip

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Other Phone: _____

Child's Name	Date of Birth	Grade
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please Note: The fee schedule for Queen of Angels School Extended Care Program will be as follows:

Before School (7:00 – 8:00 am):	$ 2.00 per child
After School (3:20 – 6:00 pm):	$ 10.00 First Child
	$15.00 Two or More Children

****There is no charge if picked up before 3:45 pm.****

LATE FEES: Any child not picked up by 6:00pm will be assessed a $10.00 late fee which must be paid before the child may return to the program.

FEES ARE DUE weekly. Students may be withheld from using the program if the account balance is $100 or more. Please notify the school office if there is a problem paying your account.

No family may use the services of the Extended Care Program unless they are registered in the school.

Please complete the Emergency Information on the back

PLEASE PRINT

Student's Name_____Grade_____Homeroom_____

Address _____City_____Zip Code_____

Date of Birth _____

Mother's Name_____Custodial Parent? Yes____ No____

Address _____City_____Zip Code_____
(if different from child)

Home Phone _____Work Phone_____Cell Phone_____

Father's Name _____Custodial Parent? Yes____No____

Address _____City_____Zip Code_____
(if different from child)

Home Phone _____Work Phone_____Cell Phone_____

In case of accident or illness, I request the Extended Care Supervisor to contact me first. If the school is unable to reach me, I hereby authorize the school to contact the following people to pick up my child and make any decision necessary for the welfare of my child.

Name_____Phone_____Relationship_____

Address_____City_____Zip Code_____

Name_____Phone_____Relationship_____

Address_____City_____Zip Code_____

Physician's Name_____Phone Number_____

Dentist's Name _____Phone Number_____

Hospital Preference (in case of emergency)_____

Remarks_____

Allergies_____

Special Health Conditions_____

Signature of Parent or Guardian_____
Date

This form MUST be returned for admittance to the Extended Care Program.