

QUEEN OF ANGELS SCHOOL—EXTENDED CARE PROGRAM
(260-483-8214, Extension 8023)

REGISTRATION/EMERGENCY INFORMATION

2020-2021

Custodial Parents' Names: _____
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 (7:30-8:00 a.m.)	\$ 2.00 per child, per day
After School (3:15-6:00 p.m.)	\$ 10.00 per day, First child
	\$ 15.00 per day, Two or more children

****There is no charge** if a child is dropped off after 7:50 a.m. and picked up before 3:30 pm.**

NOTE: Only parents and other pre-approved adults reported in your Emergency Contact information may pick up students from After-Care.

LATE FEES: Any child not picked up by 6:00 p.m. will be assessed a \$10.00 late fee which must be paid before the child may return to the program. After 6:05 p.m. a fee of \$1 per minute will be charged.

FEES ARE BILLED & DUE WEEKLY. You may pay this balance in person, send with your student, or online (website listed on invoice). 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.

Only Families registered in the school may use the services of the Extended Care Program.

Please complete the Emergency Information on the back

PLEASE PRINT (and fill in one form for each child)

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.

1) Name _____ Phone _____ Relationship _____

Address _____ City _____ Zip Code _____

2) 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.

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Student's Name _____ Grade _____ Homeroom _____

Address _____ City _____ Zip Code _____

Date of Birth _____

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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 _____

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