



**Saint John School- After School Program**  
**9 Moon Street**  
**Boston, MA 02113**

Child/Children Name(s) \_\_\_\_\_

The following person/s will be picking up my child at afterschool:

	Name	Relationship to Child
1.	_____	_____
2.	_____	_____
3.	_____	_____

An ID is required for pickup. I understand and comply with the school regulations regarding the after school dismissal procedure.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



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**After School Program Permission Slip**

I give my child/children \_\_\_\_\_ permission to  
take part in the following after school activities:

- 1) North Square Park
- 2) Occasional trips to the North End Public Library
- 3) Other short walks around the Neighborhood

IT IS AGREED THAT NO LIABILITY IS ASSUMED BY THE SCHOOL OR EMPLOYEES FOR  
INJURIES TO PERSON OR DAMAGE TO PROPERTY ON THESE TRIPS.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



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**ALLERGY AND EMERGENCY INFORMATION FORM**

**Student's Name:** \_\_\_\_\_

**Student's Address:** \_\_\_\_\_

**Home Telephone Number:** \_\_\_\_\_

**Allergies** - Please list all known.

*If your child has a severe, life threatening allergy (requires epipen) please provide us with that information as well.*

Medication allergies (list) \_\_\_\_\_

Food allergies (list) \_\_\_\_\_

Other allergies (list) - include insect stings, asthma, etc. \_\_\_\_\_

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**Where parents can be reached if not at home:**

Mother: Address: \_\_\_\_\_ Tel No. \_\_\_\_\_

Father Address: \_\_\_\_\_ Tel No. \_\_\_\_\_

**List two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached.**

1. Name \_\_\_\_\_ relation to child \_\_\_\_\_ Tel # \_\_\_\_\_

2. Name \_\_\_\_\_ relation to child \_\_\_\_\_ Tel # \_\_\_\_\_

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his/her instructions. If it is impossible to contact the physician, the school may make whatever arrangements seem necessary.

Local Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_