

**TRUE CROSS CATHOLIC SCHOOL**  
**EXTENDED DAY REGISTRATION**

**THIS FORM MUST BE FILLED OUT BY ALL FAMILIES**

*There is no registration fee for EDP. Families may use these services at any time. Any student attending a.m. EDP will be billed for the month. Afternoon EDP is charged on a daily basis at the end of each month through the FACTS Incidental Billing System. (2021-22 Rates: a.m. \$100/month and p.m. \$15/day)*

1. Child's name \_\_\_\_\_ Grade \_\_\_\_\_ Birthday \_\_\_\_\_

2. Child's name \_\_\_\_\_ Grade \_\_\_\_\_ Birthday \_\_\_\_\_

3. Child's name \_\_\_\_\_ Grade \_\_\_\_\_ Birthday \_\_\_\_\_

Mother's name \_\_\_\_\_

Address \_\_\_\_\_

Street City State Zip

Phone \_\_\_\_\_ (home) Business phone \_\_\_\_\_

Area code & number Area code & number

Cell Phone \_\_\_\_\_

Area code & number

Father's name \_\_\_\_\_

Address \_\_\_\_\_

Street City State Zip

Phone \_\_\_\_\_ (home) Business phone \_\_\_\_\_

Area code & number Area code & number

Cell Phone \_\_\_\_\_

Area code & number

Parents status: Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_

Emergency Information:

Persons authorized to pick up child(ren) enrolled other than parents:

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Please list any allergies, disabilities, restrictions or special needs that your child may have:

Child's Doctor \_\_\_\_\_ Office Phone \_\_\_\_\_

Hospital Preference \_\_\_\_\_

I agree that the staff may authorize a physician to provide emergency care in the event that I cannot be contacted immediately.

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