

Please list the names of adults who will assume responsibility for the child if parent/guardian cannot be reached or is unable to pick up the child from the Extended Day Program. Remember to have someone close in proximity on your list in case you are delayed or caught in traffic, etc.

<u>Name</u>	<u>Phone</u>	<u>Signature</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Please list any special health conditions of the child (include any allergies). Please remember, if you are called in the event your child becomes ill while at the Extended Day Program, you must pick that child up immediately.

Physician of choice: Name: _____ Phone: _____

Dentist of choice: Name: _____ Phone: _____

As parent/guardian of _____, I do herewith authorize treatment by a qualified and licensed medical doctor of the minor listed in the event of a medical emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me. I authorize responsible school authorities to send my child (properly accompanied) to an available hospital. This release is intended for the 2010-2011 school year and is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Parent/Guardian Signature: _____ Date: _____

Please include a deposit of \$100.00 with this registration form.

(\$50 of this deposit will be used for the program and \$50 will be applied to your first EDP payment.)

Make check payable to St. Paul of the Cross School. Check # _____