2024-2025 EXTENDED DAY PROGRAM REGISTRATION FORM

Family Name: _____

Address: _____

_____ Phone: _____

First Student's Name:_____Birth Date:_____24-25 Grade: _____

Second Student's Name:_____Birth Date:_____24-25 Grade: _____

Third Student's Name:_____Birth Date:_____24-25 Grade: _____

Mother's Name:_____ Business Phone: _____

Email: _____ Cell Phone/Pager: _____

Father's Name:_____ Business Phone: _____

Email: _____ Cell Phone/Pager: _____

The above-named students live with _____ and will be transported

to and from school by:_____

Please inform us of any child custody agreements: _____

_____

Please indicate below which days and times your child will attend the St. Paul of the Cross School Extended Day Program (circle your choices):

7:00am – 7:55am For: Preschool – 8th Grade Students	Monday	Tuesday	Wednesday	Thursday	Friday
2:00*/3:00pm – 4:00pm For: Preschool – 8th Grade Students	Monday	Tuesday*	Wednesday	Thursday	Friday
2:00*/3:00pm – 6:00pm For: Preschool – 8th Grade Students	Monday	Tuesday*	Wednesday	Thursday	Friday

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.

	Name	Phone	Signature
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 much 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 2024-2025 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 note a $75 fee with be charged through FACTS for this registration form.