Extended Care
Enrollment

School Year ___________

Child's Name _________________________ Child's Teacher ____________________

Please check the following as applicable:

My child will be using *Morning Extended Care* on the following days:

Mon	Tue	Wed	Thu	Fri
____	____	____	____	____

My child will be using *Afternoon Extended Care* on the following days:

Mon	Tue	Wed	Thu	Fri
____	____	____	____	____

_____My child will be using *Afternoon Extended Care* on an "as needed" basis.*

* Note: It is the responsibility of each parent(s) to notify the teacher in writing or the school office by phone whenever your child will be attending *Afternoon Extended Care*.

Transportation

Child's bus number ______

_______ My child will be a car rider

_______ My child will be a walker

Any change in transportation must be accompanied by a note to the office.

Signature ______________________________ **Date** ____________________

EMERGENCY MEDICAL AUTHORIZATION

St. Mary Extended Care Program

PURPOSE-To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority when parents or guardians cannot be reached.

Student Name____________________________Date of Birth____________Home Phone____________
(Last) (First)

Address______________________________City____________Zip Code____________

School________________________Homeroom Teacher__________________Grade__________

Parent or Guardian (Residential) Student lives with____________________________

Mother____________Work Phone____________Cell____________Home____________Pager________

Father____________Work Phone____________Cell____________Home____________Pager________

Mother's place of employment__________________Father's place of employment

In situation where the parent cannot be reached the student may be released to the following:

Name of relative or childcare provider____________________________Relationship____________

Address____________________Daytime Phone____________Cell____________Pager____________

Other name____________________Daytime phone____________Cell____________Pager____________

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

Allergies____

Health Concerns____

Medications____

The Student may also be released to the following:

Name____________________Reationship________________Phone______________Cell____________

Name____________________Relationship________________Phone______________Cell____________

Name____________________Relationship________________Phone______________Cell____________

PART I OR PART II MUST BE COMPLETED AND SIGNED

PART I – TO GRANT CONSENT

I hereby give my consent for the following medical care providers and local hospital to be called:

Doctor__________________Phone______________Dentist______________Phone______________

Medical Specialist ______________________________ Phone ______________

Local Hospital ______________________________ Phone ______________

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by the above-named doctor or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Signature of custodial/residential parent ______________________________

Address ______________________________ **Date** ____________

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DO NOT COMPLETE PART II IF YOU HAVE COMPLETED PART I

PART II – REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

____

Signature of
Custodial/residentialparent ______________ Address ______________ Date ____________