



## ST. URSULA VILLA

### AFTER-SCHOOL CARE/HOMEWORK CLUB REGISTRATION FORM 2011-2012

Please enroll your child for placement in the After School program for the 2011-2012 school year. A \$25.00 non-refundable enrollment fee is required with this registration. Please use one form per child and complete the medical form on the reverse side. We must also have a list of **three** people who may be contacted in case of an emergency. This is required by the state and your enrollment is not complete without this.

**Name of child:** \_\_\_\_\_

**Grade:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

**Mom's first and last name:** \_\_\_\_\_

**Mom's work #:** \_\_\_\_\_ **Cell:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Dad's first and last name:** \_\_\_\_\_

**Dad's work #:** \_\_\_\_\_ **Cell:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**List 3 relatives or friends who can be contacted to care for your ill child if you cannot be reached:**

**Name:** \_\_\_\_\_ **Relation:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relation:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relation:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Specific days service is needed:**

**Mon.** \_\_\_\_\_ **Tues.** \_\_\_\_\_ **Wed.** \_\_\_\_\_ **Thurs.** \_\_\_\_\_ **Fri.** \_\_\_\_\_

**Anticipated time service is needed:**

**3:00-4:00 Only** \_\_\_\_\_ **Whole Day** \_\_\_\_\_ **Other** \_\_\_\_\_

**Please list anyone who has permission to pick up your child:**

\_\_\_\_\_  
\_\_\_\_\_

# MEDICAL FORM

**Emergency Medical Authorization:** Purpose: To enable parents & 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. Part I or Part II must be completed.

## PART I: TO GRANT CONSENT

In the event reasonable attempts to contact me at home phone: \_\_\_\_\_,  
mother's cell: \_\_\_\_\_, or father's cell \_\_\_\_\_  
have been unsuccessful, I hereby give my consent for:

1. The administration of any treatment deemed necessary by the preferred physician  
Dr. \_\_\_\_\_ at \_\_\_\_\_ (phone) or the preferred dentist  
Dr. \_\_\_\_\_ at \_\_\_\_\_ (phone) or in the event the designated  
preferred practitioner is not available, by another physician or dentist.
2. The transfer of the child to the preferred hospital \_\_\_\_\_ or  
any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinion of 2 other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of surgery.

FACTS CONCERNING THE CHILD'S MEDICAL HISTORY INCLUDING ALLERGIES,  
MEDICATIONS AND ANY PHYSICAL CONDITIONS TO WHICH THE PHYSICIAN AND  
SCHOOL SHOULD BE ALERTED: \_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## PART II: REFUSAL TO CONSENT: (do not complete part II if you completed part I)

I do not give my consent for emergency medical treatment of my child. In the event of any illness or injury requiring treatment, I wish the school authorities take no action, or to:

\_\_\_\_\_  
Signature of parent or guardian: \_\_\_\_\_  
Date: \_\_\_\_\_