

ST. URSULA VILLA
HOMEWORK CLUB AND
AFTER-SCHOOL CARE
REGISTRATION FOR 2009-2010

Please enroll your child for placement in the After School program for the 2009-2010 school year. A \$15.00 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. _____

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

PLEASE FILL OUT REVERSE SIDE!

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 _____ or mother's work Phone: _____ or father's work phone: _____ 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 and/or 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: _____