



## SJCCS Extended Care Program Registration

Child's Name \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_  
Last First

Date of Birth \_\_\_\_\_

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Phone # \_\_\_\_\_ Phone # \_\_\_\_\_

Mobile # \_\_\_\_\_ Mobile # \_\_\_\_\_

Address (if other than above) Mother \_\_\_\_\_

Father \_\_\_\_\_

Persons Authorized To Pick Up Your Child (other than parent):

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

Emergency Phone Numbers

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Does your child require special medication or have allergies? (If yes, please list.)

1. \_\_\_\_\_

2. \_\_\_\_\_

Name and Phone # of Family Physician \_\_\_\_\_

Please return this form to the school office with Registration Fee of \$30.00 per family. Make checks payable to St. Joseph Catholic Church and School.