



Cathedral of the Risen Christ

Holy Family Extended Care

2018-19 Enrollment Application

Multiple Permission Form

Walking Field Trips:

I give permission to Holy Family Extended Care to take my child on supervised excursions.

Parent Signature: _____ Date: _____

Photographs:

I do consent to reproduction and/or use of any photographs or video of my child by Holy Family Extended Care in all manners, including advertising, display, exhibition, and Holy Family Extended Care's Facebook Page.

Parent Signature: _____ Date: _____

Holy Family Extended Care will not assume responsibility for a child who has not been signed in upon arrival for the day.

I have received a copy and/or read the parent handbook for Holy Family Extended Care.

Signature of Parent (or guardian)

Date

Your signature indicates the accuracy of the information provided in this packet.

*** A COPY OF THE MOST CURRENT CERTIFICATE OF IMMUNIZATIONS MUST ACCOMPANY THIS APPLICATION. APPLICATIONS WILL NOT BE ACCEPTED WITHOUT THESE RECORDS.**



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Child's Record

Child's Name:

Birth Date:

Enrollment Date:

Parent/Guardian Information

Father's Name:

Employer:

Home Address:

Employer Address:

Home Phone:

Work Phone:

Cell Phone:

Email:

Mother's Name:

Employer:

Home Address:

Employer Address:

Home Phone:

Work Phone:

Cell Phone:

Email:

Marital Status of Parents:

Married

Divorced

Not Together

Person(s) to whom the child MAY be released other than parent/guardian

Name:

Name:

Address:

Address:

Work/Cellular:

Work/Cellular:

Relationship to Child:

Relationship to Child:

Person(s) to whom the child MAY NOT be released other than parent/guardian

Name:

Name:

Address:

Address:

Work/Cellular:

Work/Cellular:

Relationship to Child:

Relationship to Child:

Person(s) who will take responsibility for the child in an emergency when the parent (or guardian) cannot be reached (one name must be given)

Name:

Name:

Address:

Address:

Work/Cellular:

Work/Cellular:

Relationship to Child:

Relationship to Child:

Signature of Parent (or Guardian)

Date



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Child's Medical Information

Child's Health Status:

Any Health related problems which caregiver should know:

Medication, if any:

Allergies, if any:

Special Concerns (glasses, hearing aid, etc.):

Any activities the child should not engage in:

Company providing health and/or accidental insurance coverage:

Medical Emergency

In case of a medical emergency, I hereby give my consent and authorization to Holy Family Extended Care to have a medical doctor, nurse, hospital or clinic provide my child with medical assistance and/or treatment. This includes taking whatever emergency medical measures are deemed necessary for the reasonable cost of such assistance and/or treatment should it occur while my child is under the care of Holy Family Extended Care. This may also involve transporting my child to a Doctor, Hospital or contacting the rescue unit for assistance.

Signature of Parent (or guardian)

Date

COMPETENCY STATEMENT:

I, _____ have determined Holy Family Extended Care competent to give or apply medication to my child. I understand the Holy Family Extended Care Director has the responsibility to assess the ability of staff to give or apply medication safely and may give or apply medication to my child.

Signature of Parent (or guardian)

Date

Varicella Disease (Chicken Pox)

Name of Child _____ has been vaccinated for the

Varicella Disease on the following date: _____.

I, _____ **verify that my child had the Varicella Disease in**
Parent (or guardian)
_____. (Year)



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After School Information

Student Information

Last Name:	First Name:
Age:	Current Grade:
Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address:	

Parent Information

Parents/Guardians	
Home Number:	Work Number:
Work Number:	Email:
Cell:	Email:

Enrollment Status

Before School Care (7:00 am - 8:00 am) - \$10/Day *Please mark which days your child will be attending*

Monday	Tuesday	Wednesday	Thursday	Friday
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

After School Care (3:00 pm - 5:30 pm) - \$15/Day *Please mark which days your child will be attending*

Monday	Tuesday	Wednesday	Thursday	Friday
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Before and After School Care (7:00 am - 8:00 am and 3:00 pm - 5:30 pm) - \$25/Day

Please mark which days your child will be attending

Monday	Tuesday	Wednesday	Thursday	Friday
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* Weekly tuition rates remain constant regardless of vacation, illness, or holidays.

* See handbook for payment policy information

*** A \$25 REGISTRATION FEE MUST ACCOMPANY THIS APPLICATION***

Parent Signature: _____ Date: _____

By signing the registration form you are in agreement with the fees set on this form. Failure to pay fees by the 5th of each month could result in termination of services.

OFFICE USE ONLY:

Start Date:

Date of Registration Fee Paid: _____ C#: _____ Amount: _____

Director's Signature: _____ Date: _____