

St. Joseph/Marquette Catholic School

AFTER SCHOOL CARE PROGRAM

REGISTRATION FORM

Student name: _____

Address: _____

Date of Birth: _____ Home #: _____

Father's Name: _____ Work #: _____

Cell #: _____

Mother's Name: _____ Work #: _____

Cell #: _____

Emergency contact: _____ Home #: _____

Work#: _____ Cell#: _____

Emergency contact: _____ Home #: _____

Work#: _____ Cell#: _____

List any special health problems (i.e. allergies, medication, heart, diabetes etc.)

If I cannot be reached, I give my permission in a medical emergency, including emergency surgery, for treatment by the doctor named below, or the emergency room at _____.

Dr. _____ Phone #: _____

Parent Signature: _____ Date: _____

Name and address to which all school billings should be sent:
