

Application Fee: \$5.00  
Date Paid: \_\_\_\_\_  
Check No: \_\_\_\_\_

**ST. PATRICK CATHEDRAL SCHOOL, 211 BROADWAY, NORWICH, CT 06360**  
**APPLICATION FORM FOR EXTENDED DAY PROGRAM**  
**(Please use back of form for all additional information that will not fit on front page)**

CHILD'S NAME: \_\_\_\_\_ GRADE: \_\_\_\_\_

AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ STARTING DATE: \_\_\_\_\_

MOTHER'S/GUARDIAN'S INFO: \_\_\_\_\_ FATHER'S/GUARDIAN'S INFO: \_\_\_\_\_

NAME: \_\_\_\_\_ NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

PARENTS' E-MAIL ADDRESSES (WORK & HOME) \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

PLACE OF WORK: \_\_\_\_\_ PLACE OF WORK: \_\_\_\_\_

**PERSON TO BE CONTACTED IN AN EMERGENCY IF PARENT CANNOT BE REACHED.**

NAME: \_\_\_\_\_ TELEPHONE NO: \_\_\_\_\_

**NAMES OF OTHERS TO WHOM YOUR CHILD MAY BE RELEASED (use back of form also)**

NAME: \_\_\_\_\_ NAME: \_\_\_\_\_

**PLEASE CIRCLE THE DAYS YOUR CHILD WILL BE ATTENDING. (Please notify the Extended Day Director in writing of any changes after this form is submitted)**

**MONDAY    TUESDAY    WEDNESDAY    THURSDAY    FRIDAY    OCCASIONALLY**

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DOES YOUR CHILD HAVE ANY MEDICAL PROBLEMS THAT WOULD PREVENT HIM/HER FROM PARTICIPATING IN ANY ACTIVITIES?    **YES** \_\_\_\_\_    **NO** \_\_\_\_\_

PLEASE EXPLAIN: \_\_\_\_\_

ANY ALLERGIES?    YES (Please list): \_\_\_\_\_    NO: \_\_\_\_\_

NAME OF PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

It is the policy of St. Patrick's Extended Day Program, in case of accident or medical emergency, to have the child treated by one of the local physicians if you are not available to take the child to his/her own physician. Also, if necessary, the child may be taken to the hospital. Naturally, if you have a local physician he will be contacted. A sincere effort is made to contact the parents, but this is not always possible. All doctors have "days off" when they are not available. So that your child may receive medical care quickly, we ask you to sign the following:

**WE HEREBY GIVE OUR PERMISSION TO THE ST. PATRICK'S EXTENDED DAY PROGRAM STAFF TO HAVE OUR CHILD TREATED BY A READILY AVAILABLE PHYSICIAN AND/OR HOSPITAL IN CASE OF AN ACCIDENT OR MEDICAL EMERGENCY, IF WE, AS PARENTS, ARE NOT AVAILABLE TO TAKE HIM/HER TO OUR OWN DOCTOR.**

**SIGNATURE OF PARENT/GUARDIAN: \_\_\_\_\_ DATE: \_\_\_\_\_**