

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

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: _____