

# ST. HELEN CATHOLIC SCHOOL

Registration fee  
\$30/child

## EXTENDED DAY PROGRAM APPLICATION

Student Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Grade: \_\_\_\_\_  
Address/Street: \_\_\_\_\_ Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_  
Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_  
Father's Work: ( \_\_\_\_\_ ) \_\_\_\_\_ Mother's Work: ( \_\_\_\_\_ ) \_\_\_\_\_  
Father's Cell: ( \_\_\_\_\_ ) \_\_\_\_\_ Mother's Cell: ( \_\_\_\_\_ ) \_\_\_\_\_

### **Authorized representatives to pick up children and for emergencies:**

Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone: \_\_\_\_\_

**List any special conditions that your child may have, such as FOOD ALLERGIES, allergies, illness, long term prescribed medication, or physical disability that would hinder the student from indoor /outdoor activities.**

## EMERGENCY MEDICAL CONSENT AND INFORMATION

**In the event I cannot be reached to make arrangements for emergency medical attention, I authorize the Extended Day Program to take my child to the nearest hospital or doctor.**

Extended Day  
Use only

Personal Physician Name: \_\_\_\_\_ Phone( \_\_\_\_\_ ) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
Hospital Preference: \_\_\_\_\_ Phone: \_\_\_\_\_

**I give my consent for necessary emergency treatment by Extended Day and/or physician and/or hospital in my absence.**

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_\_  
**Date**

Please circle all that apply: Morning 6:30-7:30 AM      Afternoon: 3:00-6:00 PM      As needed: AM/PM

**Rates:**                      AM: \$60/month                      PM: \$130/month                      Daily: \$20/Day  
AM/PM: \$180/month

**Late pickup fees: \$5 per child late charge and \$1/minute/child after 6:00 p.m. to be paid at pickup. There is no grace period.**