St. Francis De Sales School Extended Day Program

REGISTRATION/EMERGENCY FORM

Office Use Only
Registration Fee ______
Acknowledgement ______

Please PRINT in BLACK ink

Student will attend:_____Morning Care (7:00 a.m. – 7:45 a.m.)
_____After School/Monthly Rate _____After School/Daily Rate _____After School/Hourly Rate

Student Name: Last__________________________ First_______________________ Date of Birth_______________

Place of Birth: ____Grade for 2009/2010_________________

Father's Name: Last__________________________ First___________________________ Middle Initial__________

Address_______________________________ City_____________Zip_________Home # ( ) ___________________

Place of Employment________________________Occupation ______________Email Address ____________________

Work # ( ) ____________________ Cellular # ( ) _____________________ Pager # ( ) ____________________

Mother's Name: Last__________________________ First__________________________ Middle Initial__________

Address (if different) ____________________ City_____________Zip_________Home # ( ) ___________________

Place of Employment________________________Occupation ______________Email Address ____________________

Work # ( ) ____________________ Cellular # ( ) _____________________ Pager # ( ) ____________________

Guardian/Other Name: Last_______________________ First____________________ Relationship_______________

Address_______________________________ City_____________Zip_________Home # ( ) ___________________

Place of Employment________________________Occupation ______________Email Address ____________________

Work # ( ) ____________________ Cellular # ( ) _____________________ Pager # ( ) _____________________

Child lives with: Mother ________ Father _________ Stepmother ________ Stepfather _________ Other ____________

PERSONS TO BE CONTACTED IN CASE OF EMERGENCY WHEN PARENT/GUARDIAN CANNOT BE REACHED

1. ____ Phone # ( ) _________________ Relationship ________________

2. ____ Phone # ( ) _________________ Relationship ________________

3. ____ Phone # ( ) _________________ Relationship ________________

Medical Information:
Special Health Instructions: (Allergies, Medications, etc.) ____

Insurance Carrier : ____ Group Policy # : ______________________

Physician ____ Phone # ( ) ____________________________

Hospital Preference ____ Phone # ( ) ____________________________

I ________________________________, do hereby authorize school administration to render first aid for illness or injury to my child named above. In the event of a medical emergency, I authorize Extended Day administration to have my child transported to the nearest hospital/emergency care center for emergency medical treatment and to contact my child's physician and one of the persons listed above. I further authorize the release of the above medical information to all medical personnel providing treatment. I agree to be solely responsible for the payment of all expenses incurred in such an emergency.

I do hereby release, hold harmless and indemnify the Most Reverend Daniel N. DiNardo, Archbishop of the Diocese of Galveston-Houston and his successors in office, the Diocese of Galveston-Houston, St. Francis De Sales School and any other of their officers, agents, employees or representatives ("Released Parties") from any and all liability, claims, losses, or expenses arising from personal injury, death, or loss of or damage to property arising from any medical treatment received and/or transportation to the nearest hospital/emergency care center.

Signature of Parent/Guardian: ____ **Date Signed:** ____________________