St. Katharine Drexel School

Before/After School Child Care Registration Form

* Person picking up child must provide photo identification

Parent/Guardian Information

Mother/Guardian: First Name: _____ M.I. _____ Last Name: _____

Address: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Email: _____

Occupation: _____ Employed By: _____

Work Address: _____

Work Phone: (_____) _____ Work Hours: _____

[ ] Custodial Parent (If married, mark both parents)

Father/Guardian: First Name: _____ M.I. _____ Last Name: _____

Address: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Email: _____

Occupation: _____ Employed By: _____

Work Address: _____

Work Phone: (_____) _____ Work Hours: _____

[ ] Custodial Parent (If married, mark both parents)

Child Information

1st Child: First Name: _____ M.I. _____ Last Name: _____

Name child prefers to be called: _____ Grade/Class: _____

Child's Address:_____

Gender: [ ] Male [ ] Female Date of Birth: _____

List any existing medical conditions, medication and/or special attention your child may require?

_____

_____

Allergies: _____

Pediatrician's Name: _____ Phone: (_____) _____

Address: _____

2nd Child: First Name: _____M.I. _____ Last Name: _____

Name child prefers to be called: _____ Grade/Class: _____

Child's Address:_____

Gender: [ ] Male [ ] Female Date of Birth: _____

List any existing medical conditions, medication and/or special attention your child may require?

_____

_____

Allergies: _____

Pediatrician's Name: _____ Phone: (_____) _____

Address: _____

3rd Child: First Name: _____M.I. _____ Last Name: _____

Name child prefers to be called: _____ Grade/Class: _____

Child's Address:_____

Gender: [ ] Male [ ] Female Date of Birth: _____

List any existing medical conditions, medication and/or special attention your child may require?

_____

_____

Allergies: _____

Pediatrician's Name: _____ Phone: (_____) _____

Address: _____

4th Child: First Name: _____M.I. _____ Last Name: _____

Name child prefers to be called: _____ Grade/Class: _____

Child's Address:_____

Gender: [ ] Male [ ] Female Date of Birth: _____

List any existing medical conditions, medication and/or special attention your child may require?

_____

_____

Allergies: _____

Pediatrician's Name: _____ Phone: (_____) _____

Address: _____

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Emergency Contacts & Authorized Pickup Persons

1st Contact/Pick Up: Name: _____ Phone: (_____) _____

Relationship to the Child: _____

[ ] Able to pick up all children in the family

[ ] Not able to pick up the following children: _____

2nd Contact/Pick Up: Name: _____ Phone: (_____) _____

Relationship to the Child: _____

[ ] Able to pick up all children in the family

[ ] Not able to pick up the following children: _____

3rd Contact/Pick Up: Name: _____ Phone: (_____) _____

Relationship to the Child: _____

[ ] Able to pick up all children in the family

[ ] Not able to pick up the following children: _____

4th Contact/Pick Up: Name: _____ Phone: (_____) _____

Relationship to the Child: _____

[ ] Able to pick up all children in the family

[ ] Not able to pick up the following children: _____

Additional Comments & Information

Is there any other information that would be helpful to our management and teaching staff?

_____

_____

_____

**Submit the $25 registration fee along with this form.

Signature

Parent's Signature: _____ Date: _____

By entering my full name, I attest that this constitutes my legal electronic signature on this form.

We will hold admission to 30 students at the onset of the program to ensure a staffing ratio of 15 students to one adult supervisor.

Thank You!