ST. JOSEPH SCHOOL
EXTENDED DAY CARE REGISTRATION AND MEDICAL RELEASE

This form will accompany your student to the hospital
if emergency treatment becomes necessary.

PLEASE COMPLETE THE FOLLOWING INFORMATION

Name:______________________________ **Grade:**________ **Room No.:**________
Name: ______________________________ **Grade:**________ **Room No.:**________
Name: ______________________________ **Grade:**________ **Room No.:**________

Family Name: _______________________ Mother: ___________ Father:_____________
Address:____
Home Phone: ____________________ Cell Phone Mom_____________________
Cell Phone Dad _____________________

Father's Employment: _________________________ Phone No. ______________
Place

Mother's Employment: ________________________ Phone No. ______________
Place

If both parents are unavailable, the following adults may be called:

1. _______________________________________ Phone No. ______________________

2. _______________________________________ Phone No. ______________________

If emergency treatment is necessary, I hereby give permission for my child to be taken to the nearest doctor or hospital and agree to pay all fees in connection with such treatment or service not covered by insurance. I also authorize the treatment of my minor child by a qualified and licensed medical doctor after a reasonable effort has been made to reach me.

____ **Date:** ___________________
Signature of Parent or Guardian

Please list any known allergies for your child/children: __________________________
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