SAINT JOSEPH SCHOOL
25 SQUIRE STREET
NEW LONDON, CONNECTICUT

AFTER SCHOOL CARE PROGRAM REGISTRATION

Child/Children Name & Grade: ______________________________

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Parent or Guardian: ______________________________

Address: ______________________________

Phone Number: (Home) ____________________ (Work) ____________________

Emergency Contact: ____________________ Tele. No: ____________________

Allergies or Medical Concerns: ______________________________

Circle the days your child will attend: M T W Th F Various/As Needed

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In case of emergency, the following person(s) are authorized to pick up my child/children from After School Program (Identification required at time of pick up):

Name: ____________________ Tele. No.: ____________________

Name: ____________________ Tele. No.: ____________________

Name: ____________________ Tele. No: ____________________

Name: ____________________ Tele. No.: ____________________

By signing this form I agree to the appropriate payment. Payment should be made prior to the service given and checks are made to St. Joseph School. Any delinquent balance beyond 15 days will result in suspension from the program until payment is received.

I also understand that all rules of behavior that apply during the school day also apply during the After School Care Program.

All health issues (i.e., asthma, allergies, etc.) must be discussed with the School Nurse, Mrs. Tejera prior to your child/children attending the program. Mrs. Tejera will advise the After School Program Director, Mrs. Bustamonte of the health issue(s) as per the Medication Policy.

______________________________ ____________________

Signature of Parent or Guardian Date