

INFORMATION FORM-EXTENDED DAY PROGRAM

Family Name: \_\_\_\_\_

Name of Child	Grade	Allergies

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

\*Please indicate the time that your child or children will normally be dropped off in the morning: \_\_\_\_\_

\*Please indicate the time that your child or children will normally be picked up in the evening: \_\_\_\_\_

Persons authorized to pick-up your child or children:

1. Name \_\_\_\_\_ Phone: \_\_\_\_\_
2. Name \_\_\_\_\_ Phone: \_\_\_\_\_
3. Name \_\_\_\_\_ Phone: \_\_\_\_\_

Children will NOT be released to any persons not on this list unless we have been notified by parents in writing. Identification may be required.

Child's Physician: \_\_\_\_\_ Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Hospital of Choice: \_\_\_\_\_

Emergency numbers:

1. Name \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_
2. Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

I hereby authorize emergency medical care for my child, \_\_\_\_\_, during attendance at the St. Mary Extended Day Program if, in judgment of the staff, treatment is required for an injury or illness. I hereby authorize the administering of anesthetics and recourse to other procedures deemed necessary by the attending physician.

Parent/Guardian Signature: \_\_\_\_\_

Date \_\_\_\_\_