



AUTHORIZED PICK-UP/EMERGENCY CONTACTS

(Please attach a recent photo for each.)

Name: _____ Relationship to Child: _____

Phone Numbers During Extended Day Program Hours: Home: _____

Work: _____ Cell/Pager: _____

Name: _____ Relationship to Child: _____

Phone Numbers During Extended Day Program Hours: Home: _____

Work: _____ Cell/Pager: _____

Name: _____ Relationship to Child: _____

Phone Numbers During Extended Day Program Hours: Home: _____

Work: _____ Cell/Pager: _____

HEALTH HISTORY

Please list any **allergies** (food, insect, plants) your child has:

Please list any dietary needs you child has: _____

Please list any regular Medicines your child takes: _____

Note: Extended Day Program personnel will not dispense any medications.

AGREEMENT

I wish to register my child in the Guardian Angels School Extended Day Program. I fully understand that my Registration Fee of \$50.00 per family submitted with this form for admission into the program is non-refundable.

Signature: _____ Date: _____

I give permission for the Director and Staff of the Extended Day Program to view any pertinent health and school records concerning my child.

Signature: _____ Date: _____