Please complete the form and return it to the school office below to register your child(ren) for our care program.

Child's Name:
First Name:_____ Last Name:_____

Child's Birthdate: (MM/DD/YYY): _____

Child #2 (if applicable)
Child's Name:
First Name:_____ Last Name:_____

Child's Birthdate: (MM/DD/YYY): _____

Child #3 (if applicable)
Child's Name:
First Name:_____ Last Name:_____

Child's Birthdate: (MM/DD/YYY): _____

Mother's Information:
First Name:_____ Last Name:_____

Mother's Phone Number: _____

Address: _____

City:_____ State:_____

Zip/Postal Code:_____

Mother's Employer: _____

Mother's Work Phone Number:_____

Mother's Email:_____

Father's Information:
First Name:_____ Last Name:_____

Father's Phone Number: _____

Address:(if applicable) _____

City:_____ State:_____

Zip/Postal Code:_____

Father's Employer: _____

Father's Work Phone Number:_____

Father's Email:_____

EMERGENCY INFORMATION

In the event that my child may require emergency medical, dental, or surgical care while I am unable to be reached, I hereby give my consent to medical, dental, or surgical treatment to:

Doctor: _____ Clinic: _____

Doctor Phone Number: _____

Clinic Address: _____

City:_____ State:_____

Zip/Postal Code:_____

Hospital Preference:_____

Dentist: _____

Dentist Phone Number: _____

Address: _____

City:_____ State:_____

Zip/Postal Code:_____

I agree to pay all the costs and fees contingent on emergency care or treatment for my child as secured or authorized under this consent. ____ I do ____ I don't

Emergency Contact:(someone other than a parent):

First Name:_____ Last Name:_____

Relationship to child(ren): _____

Emergency Contact Phone Number:_____

Emergency Contact 2:(someone other than a parent):

First Name:_____ Last Name:_____

Relationship to child(ren): _____

Emergency Contact Phone Number:_____

Pick Up Permission Please select yes or no for the following:

I hereby give permission for my child(ren) to leave the center for field trips provided by the center, or on foot. _____ Yes _____ No

I grant St. Luke's Care Program permission to take photographs of my child(ren) engaging in center activities. _____ Yes _____ No

I hereby give permission for my child(ren) to leave the center with the following persons named below. It is the responsibility of the parent to notify the center of any changes.

Pick Up Person:
First Name:_____ Last Name:_____

Relationship to child(ren): _____

Pick Up Person:
First Name:_____ Last Name:_____

Relationship to child(ren): _____

MEDICAL
Please sign and date below stating that your child's medical history is located in the school nurse's office.

Parent Signature:_____ Date:_____

Please sign and date below stating that your child(ren) is up to date on medical requirements.

Parent Signature:_____ Date:_____

Please select the option that best fits the needs of your family:

- ❏ AM & PM (6:55-8:10 AM & 3:15-5:30 PM)
- ❏ AM (6:55-8:10 AM)
- ❏ PM (3:15-5:30 PM)
- ❏ Part-time AM & PM (3 days or less)
- ❏ Part-time AM (3 days or less)
- ❏ Part-time PM (3 days or less)

Occasional Use: Will be offered if there is enough interest to be financially feasible.

- ❏ Early Dismissal (12:30-5:30 PM)
- ❏ No School Days (6:55 AM - 5:30 PM)