



**St. Mary of the Assumption School  
EXTENDED CARE**

Family Last Name (please print) \_\_\_\_\_ Phone # \_\_\_\_\_

Child's Name (please Print) \_\_\_\_\_ Grade \_\_\_\_\_

**\*Check one: Morning care only \_\_\_ Afternoon care only \_\_\_ Morning and afternoon care**

**Siblings in the Program**

1. \_\_\_\_\_ Grade \_\_\_\_\_ 2. \_\_\_\_\_ Grade \_\_\_\_\_

AS THE PARENT/LEGAL GUARDIAN, I GIVE ST. MARY OF THE ASSUMPTION SCHOOL EXTENDED CARE PROGRAM CONSENT TO PROVIDE FOR MY CHILD ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OR DENTIST (D.S.S.). THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB, OR WELL-BEING OF MY CHILD.

Parent's Signature \_\_\_\_\_ Print Name \_\_\_\_\_

Date \_\_\_\_\_

The above name child has the following ALLERGIES:

\_\_\_\_\_

**Parent Information**

Mother's/Guardian's Name \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Father's/Guardian's Name \_\_\_\_\_ Cell Phone # \_\_\_\_\_

**I AUTHORIZE THE EXTENDED DAY CARE PROGRAM STAFF PERMISSION TO RELEASE MY CHILD(REN) TO INDIVIDUALS LISTED ON THE EMERGENCY CARE INFORMATION AND BELOW.**

**Emergency Contacts**

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Name \_\_\_\_\_ Phone # \_\_\_\_\_

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