CHRIST THE KING AFTER CARE PROGRAM

REGISTRATION FORM (hours 3:00 pm – 6:00 p.m.)

This competed form must be accompanied by a $5 registration fee for each child. The fee is non-refundable. Return this form and fees to the school office (please make checks payable to Christ the King).

Family Name _____

Please list all children in family that are to be enrolled in the After Care Program and circle which days children are expected to attend:

_____ Grade: _____ M T W TH F

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Total amount of payment enclosed to register child(ren): _____ cash____ check _____

Please note that there is a $5.00 per minute charge for any children being picked up after 6:00 P.M. in addition to the daily rate.

Cost of After Care: 1 child $10.00/day; 2 children $15.00/day; 3 children $20.00/day

PAYMENT IS REQUIRED WHEN CARD IS FULL OR SPEAK TO MRS. SHANKS REGARDING A PAYMENT PLAN.

CONTACT/PICK-UP INFORMATION

We ask that you provide us with at least TWO numbers where we can reach you, a spouse, or an additional emergency contact, specifically between the hours of 3:00 p.m.-6:00 p.m.

Mother's name: _____

Best contact number: _____ 2nd contact number: _____

Father's name: _____

Best contact number: _____ 2nd contact number: _____

Emergency Contact: _____ Relationship: _____

Best contact number: _____ 2nd contact number: _____

Please list any allergies or any other health issues we should know about below

_____

_____

OVER→

Please list all parties that are allowed to pick up your child(ren).

_____

_____

_____

_____

_____

Parental Consent for
Medication Administration to their Child

Date: _____ School: Christ the King

Student: _____ Grade: _____

My child is to receive _____ medication according to

The physician's directions given for _____ .

The treatment will last _____ .

My child has _____ drug allergies.

I give my permission for this medication to be administered to my child at school. The school has my permission to call the physician with any questions regarding the medication.

I understand and acknowledge that any medication to my child during school will more than likely not be administered by a registered nurse or other medical professional. In consideration of the school administering medication to my child pursuant to this authorization, I hereby release and hold harmless the school, the Archdiocese of St. Louis, and their employees, agents or representative, from any liability that may arise from administering medication to my child.

Signature: _____

Relationship to student: _____

Physician Contact Information: _____

Physician Consent for Medication Administration

Date: _____ Name of Student: _____

Medication: _____ Dose: _____

Time Interval: _____

Diagnosis or reason for treatment: _____

Side effects to look for: _____

Restrictions: _____

Signature: _____