

**St. Joseph Catholic School
Extended Care Programs
Application
2011-12**

Before School Care (Available to St. Joseph's students in grades K-8)
There is no registration fee for Before School Care.

_____ **Full-Time** (Yearly fee-\$300.00 per student, payable in 10 installments through FACTS or in one lump sum)

_____ **Part-Time** (Daily rate - \$3.00 per student, billed at the end of each month)

After School Care (Available to St. Joseph's students in grades PreK-7 on regular days of school. **There is no ASC on early release days**)
Registration Fee- \$75.00 per family

_____ **Full-Time, 2:45-6:00** (Yearly fee - \$1,400.00 per student)

Payment Options(Please check one)

_____ FACTS (10 monthly payments)

_____ Pay in Full by 8/1/11

_____ **Part-Time** (limited to 3 days a week – billed at end of each month)

\$ 5.00 per child if picked up by 3:45pm.

\$10.00 per child if picked up by 4:45pm.

\$15.00 per child if picked up by 5:45pm.

Family name: _____

Student: _____ Grade _____

Student: _____ Grade _____

Student: _____ Grade _____

Student: _____ Grade _____

Address: _____

Home Phone: _____ Work Phone: _____

Email Address _____

2011-12
After School Care
Student Information Sheet

Family Last Name _____ ASC Status: FT PT

Student's Name _____ Part Time – limited to 3 days a week

Student's Name _____ FACTS ___ Paid in full

Student's Name _____ Registration Fee Paid _____(check #)

Student's Name _____

Home Address _____

Home Phone # _____

Father's Name _____ Work# _____

Email address _____ Cell _____

Mother's Name _____ Work# _____

Email address _____ Cell # _____

People Authorized to pick up child(ren) if parent(s) are unavailable:

Name _____ Phone # _____ Relation _____

Name _____ Phone # _____ Relation _____

Name _____ Phone # _____ Relation _____

Name _____ Phone # _____ Relation _____

Name _____ Phone # _____ Relation _____

Name _____ Phone # _____ Relation _____

Name _____ Phone # _____ Relation _____

People Prohibited from picking up child(ren)

Name _____ Relation _____

Name _____ Relation _____

Health Information

Please specify allergies or current daily medications for each student:

Name _____ Allergy _____

Medications _____

Name _____ Allergy _____

Medications _____

Name _____ Allergy _____

Medications _____

Name _____ Allergy _____

Medications _____

Do any of the above students have any other health conditions? Yes _____ No _____

If yes, please specify which student and the concern:

Local Physician's Name

Physician's Office #

In case of emergency, accident, or serious illness to the student(s) named above in which medical treatment is required, I (parent/guardian) request the school to contact me. If the school is unable to reach me, my signature below authorized the school to exercise their own judgment in contacting the physician indicated above and to follow his/her instructions. If the physician is unavailable, the school may make whatever arrangements are necessary of transport the student to a hospital emergency room.

Parent/Guardian Signature _____ Date _____

After School Activities (K4J, Band, Play, Sports, Speech, etc.)

Child's Name _____ Activity _____ Time _____
M T W T F

Child's Name _____ Activity _____ Time _____
M T W T F

Child's Name _____ Activity _____ Time _____
M T W T F

Child's Name _____ Activity _____ Time _____
M T W T F

Child's Name _____ Activity _____ Time _____
M T W T F

Child's Name _____ Activity _____ Time _____
M T W T F