SS. PETER AND PAUL AFTER SCHOOL PROGRAM REGISTRATION

5480 Main Street
Williamsville, NY 14221
Phone: 632-6146 ext. 252
Fax: 626-0971

Student's Name(s):_____

Address _____

Home Phone: _____ Cell (mom) _____ Cell (dad) _____

Work (mom) _____ Work (dad) _____

Email Address : _____

Student's special needs (include physical and emotional problems, allergies, etc.) _____

_____

_____

To whom your child may be released : _____

_____

PLEASE CHECK THE APPROPRIATE CATEGORY

My child/children will be attending on the following days on a regular basis:

Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____

My child/children may be attending throughout the year and I will send a note. _____

My child/children _____ has/have my permission to attend Ss. Peter and Paul After School Program. I understand that participants will play on the playground, in the gym, and in the cafeteria. In addition I understand that the After School Program staff is not responsible for my child's homework.

_____ _____

Parent Signature Date

Please fill in reverse side.

Ss. Peter & Paul

ASP EMERGENCY CONTACT FORM

Student's Name _____ **Grade** _____

As the parent/legal guardian of _____, I request in my absence the above named child be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize *physicians, dentists*, and *staff*, **duly licensed** as *Doctors of Medicine* or *Doctors of Dentistry* or other licensed *technicians* or *nurses*, to perform any *diagnostic procedures*, *treatment procedures*, *operative procedures* and *x-ray treatment* for the above minor. I have not been given a guarantee as to the results of the examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above child.

Date of child's Birth: ____/____/____ (Month / Day / Year) Date of last Tetanus Booster: ____/____/____ (Month / Day / Year)

Known Allergies of this player *(including any allergies to medicine)*: _____

_____

Any other medical problems, which should be noted: _____

_____

Current Medications: _____

Family Physician: _____ **Phone:** ( ) _____

PARENT/GUARDIAN: _____

Address: _____
(Street) (City) (State) (Zip code)

Home Phone: ( ) _____ Work Phone: ( ) _____ FAX: ( ) _____

EMERGENCY CONTACT *(if parent is unavailable:* _____

Address: _____
(Street) (City) (State) (Zip code)

Home Phone: ( ) _____ Work Phone: ( ) _____ FAX: ( ) _____

PERSON RESPONSIBLE FOR CHARGES *(if different from Parent/Guardian)* _____

Address: _____
(Street) (City) (State) (Zip code)

Home Phone: ( ) _____ Work Phone: ( ) _____ FAX: ( ) _____

INSURANCE CARRIER: _____ **I.D. #** _____

Address: _____
(Street) (City) (State) (Zip code)

Phone: ( ) _____

Signature of Parent/Guardian: _____

Date: _____