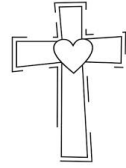


St. John the Baptist Catholic School
 Jefferson, WI
 www.stjohnbaptist.net
 Phone: 1.920.674.5821



Father Thomas Coyle, Pastor
 Terry Tinkle, Principal
 Lori Becker, Administrative Assistant
 Susan Loof, Director of Special Services

Extended Care Registration

(Office Use)

Registration Fee: \$35.00 Per Child

PAID BY:

Check: #

Cash:

School Year: 20__-20__

FAMILY NAME: _____

CHILD'S NAME: _____ BD: ___/___/___

_____ BD: ___/___/___

_____ BD: ___/___/___

_____ BD: ___/___/___

ADDRESS: _____

CITY: _____ ZIP: _____

PHONE: (_____) _____ - _____

MOTHER/GUARDIAN INFORMATION: (CIRCLE) SAME AS CHILD DIFFERENT

(PLEASE FILL IN BELOW IF DIFFERENT)

ADDRESS: _____

PHONE: (_____) _____ - _____ (HOME)

(_____) _____ - _____ (CELL)

_____ (EMAIL)

FATHER/GUARDIAN INFORMATION: (CIRCLE) SAME AS CHILD DIFFERENT

(PLEASE FILL IN BELOW IF DIFFERENT)

ADDRESS: _____

PHONE: (_____) _____ - _____ (HOME)

(_____) _____ - _____ (CELL)

_____ (EMAIL)

EMERGENCY CONTACT INFORMATION

(PERSON WITHIN A 20 MILE RADIUS OF EXTENDED CARE OTHER THAN PARENT OR GUARDIAN)

PRIMARY EMERGENCY CONTACT:

NAME: _____

ADDRESS: _____

CITY: _____ ZIP _____

PHONE: (_____) _____ - _____ (HOME)

(_____) _____ - _____ (CELL)

RELATIONSHIP TO CHILD: _____

SECONDARY EMERGENCY CONTACT:

NAME: _____

ADDRESS: _____

CITY: _____ ZIP _____

PHONE: (_____) _____ - _____ (HOME)

(_____) _____ - _____ (CELL)

RELATIONSHIP TO CHILD: _____

MEDICAL INFORMATION

DOCTOR: _____ PHONE: _____

DENTIST: _____ PHONE: _____

If emergency treatment is required, and parents cannot be reached immediately, may the Extended Care authorities use their own judgment in calling the doctor or dentist listed above, if not available, an alternate doctor?

YES

NO

If NO, indicate plan to plan:

**OTHER PERSONS AUTHORIZED TO PICK UP MY CHILD FROM
EXTENDED CARE:**

NAME: _____

PHONE: (_____) _____ - _____

RELATIONSHIP TO CHILD: _____

NAME: _____

PHONE: (_____) _____ - _____

RELATIONSHIP TO CHILD: _____

NAME: _____

PHONE: (_____) _____ - _____

RELATIONSHIP TO CHILD: _____

HEALTH HISTORY

ALLERGIES: YES NO
 EXPLAIN:

ASTHMA: YES NO
 EXPLAIN:

SERIOUS ILLNESS, ACCIDENTS, SPECIAL INSTRUCTIONS, OR OTHER THINGS THE CAREGIVER SHOULD
KNOW (USE BACK OF FORM IF NECESSARY)