

**St. Raphael's Extended Day Program
Information/Emergency Form 20____/20____**

Child: _____ Birth date: _____ Child : _____ Birthdate: _____

Child: _____ Birthdate: _____ Child: _____ Birthdate: _____

Address: _____ Telephone #: _____

City: _____ Zip Code: _____

Parent/Guardian name(s): _____ Work #: _____ Cell # _____

_____ Work #: _____ Cell # _____

Days Attending: Monday Tuesday Wednesday Thursday Friday Pick-up Time: _____

Any physical conditions/special needs that we should be aware of?* _____

Allergies: (specify child)* _____

*Continue on back, if necessary.

Persons whom you approve to pick up child (Driver's license/Photo ID required at time of pick-up).

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Emergency contact: _____ Work #: _____
Cell #: _____
Home #: _____

Emergency contact: _____ Work #: _____
Cell #: _____
Home #: _____

Emergency contact: _____ Work #: _____
Cell #: _____
Home #: _____

Physician: _____ Telephone #: _____

Clinic: _____ Telephone #: _____

Dentist: _____ Telephone #: _____

In case of accident, serious illness, or ingesting of a hazardous substance, I give St. Raphael Extended Day Program personnel my permission to contact the physician or emergency hospital (911), call Poison Control, or administer syrup of ipecac, if I cannot be reached.

Parent/Guardian Signature: _____ Date: _____

