Office Use Only:

Registration Fee Received for:

Early Care _____
After Care: _____
Check Number: _____
Date _____

PRINCE of PEACE CATHOLIC SCHOOL

K5-8 EARLY CARE/AFTER SCHOOL CARE REGISTRATION FORM

FAMILY INFORMATION

Parent(s) Name(s): _____

Address: _____

Home Phone: Father: _____ Mother: _____

Cell Phone: Father: _____ Mother: _____

Work Phone: Father: _____ Mother: _____

FEE SCHEDULE

	REGISTRATION	DAILY FEE	HOURS AVAILABLE
EARLY CARE K5-8th	**$30.00/child**	**$4.00/day/child**	**7:00-7:30 a.m. M—T—W—TH—F**
AFTER CARE K5-8th	**$30.00/child**	**$11.00/day/child**	**3:15-5:45 p.m. M—T—W—TH—F**

*****Registration Fees are due when forms are submitted or may be billed through FACTS.
*****Daily charges and late fees will be billed monthly through FACTS incidental billing.

STUDENT NAME	STUDENT GRADE	EARLY CARE	AFTER CARE	BOTH
1.				
2.				
3.				
4.				

Late Pick Up Fee: A late fee of $1.00/minute/child will be assessed for any child picked up after 5:45 p.m.

******Students in Early/After Care must abide by all policies and regulations as stated in the Student/Parent Handbook.

Parent's Signature: _____ Date: _____

PRINCE of PEACE
CATHOLIC SCHOOL

EARLY/AFTER CARE HEALTH INFORMATION
PARENTAL AUTHORIZATION

EMERGENCY CONTACTS

NAME	RELATIONSHIP TO CHILD	PHONE NUMBER
1.		
2.		
3.		

HEALTH CARE INFORMATION

STUDENT NAME	PHYSICIAN AND PHONE	DENTIST AND PHONE
1.		
2.		
3.		
4.		

In the event of a serious injury or accident which requires immediate emergency attention and the parent or designee cannot be reached, I hereby authorize the Early or After Care Director and Prince of Peace Catholic School to transport my child(ren):

_____

_____

_____

by ambulance to the nearest hospital or health care facility. I further authorize any and all medical treatment deemed necessary for the treatment of my child(ren). Every reasonable effort will be made to contact the parents and/or guardians or other designated adults for consultation regarding the injury and/or treatment.

Insurance Company: _____
Policy Number: _____
Hospital Preference:
1. _____
2. _____

Parent's Signature: _____ Date: _____