St. John the Baptist Catholic School

☐ **BEFORE SCHOOL CARE REGISTRATION 7:00-7:30 AM**

☐ **AFTER SCHOOL CARE REGISTRATION 3:00-5:30 PM**

Check one or both as applicable*

Child's Name_____

Parent's Name_____

Parent's Cell phone number_____

Allergies: _____ Yes___ No____

Chronic or recurrent illness, or disorders, handicaps, serious injury or operations (including asthma) _____ Yes____ No____

Does your child take medication for any of the above conditions? Yes____ No_____

Name of medication_____

Are there any special provisions or medical restrictions for your child? Yes___ No____

What procedures should we do if your child has a problem related to his/her medical condition during the program's hours? _____

_____

Are there any custodial concerns regarding the child? Yes____ No____

Please give any further information which you believe will be helpful to staff in understanding and caring for child: _____

_____

I _____, authorize St. John the Baptist Catholic School to charge my FACTS account for charges incurred on the fifteenth of the following month. By signing this form, you authorize St. John the Baptist Catholic School to charge your account for the monthly charges assessed for extended care on or after the date indicated above. This permission is for the transaction listed above and does not allow for additional unrelated debits or credits to your FACTS account.

***$20.00 Registration fee applied and billed through FACTS upon submission to school office**

Parent Signature Date