Faith West Extended Care Program

Student Information and Medical Release

Student Name: _____Date of Birth: _____Age_____Grade_____

Student Name: _____Date of Birth: _____Age_____Grade_____

Student Name: _____ Date of Birth: _____ Age_____ Grade_____

Address: _____

Mother's Name: _____Cell Phone: _____ Work Phone: _____

Father's Name: _____Cell Phone: _____ Work Phone: _____

Physician's Name: _____Phone: _____

Physician's Address:_____

Emergency Medical Policy

In case of an emergency, illness, or accident, the child will be given first aid and the parent/guardian will be notified. If the parent/guardian or the child's physician cannot be reached, the child will be taken to the nearest available emergency room. Faith West After Care does not assume responsibility for payment of hospital, physician, or ambulance fees. In the event I/we cannot be reached to make arrangements for emergency medical care at the time of an accident or illness, I/we hereby authorize Faith West Extended Care to take my/our child to the nearest available emergency room.
If I/we cannot be reached in case of emergency, please notify one of the following:

Emergency Contact 1: _____Phone: _____Relationship to Child: _____

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Authorization for Emergency Medical Care

I/We, the parent(s) or legal guardian(s) of the student listed above, authorize any licensed Texas physician or dentist to provide necessary X-rays, anesthesia, medical or dental treatment, surgical care, or hospital services for our child, as approved by a Faith West Extended Care staff member. We also permit the physician or dentist to consult other specialists as needed. This consent is given in advance to allow responsible parties to act in the child's best interest and remains valid for one school year unless revoked in writing.

_____ _____ _____ _____

Father/Legal Guardian Date Mother/Legal Guardian Date

PARENTAL AUTHORIZATION FOR STUDENT PICK-UP

Please list **all** persons authorized to pick up student (list driver's license numbers, if possible):

Name	**Phone Number**

Faith West Extended Care Program

Registration Form

Registration fee of $25.00 per child

Mother's Name _____ email address _____

Father's Name _____email address _____

Please Circle One:

Three Day - $265 Four Day - $350 Five Day - $435 Fridays Only – $450 Drop-in

Select Payment Method:

ACH ($5.00 per month) routing #_____ checking account # _____

Credit Card (4.5% fee) credit card # _____ expiration date _____

In the event your child(ren) must be picked up early due to non-emergency illness or school closure, list those individuals who would be most able to pick up your child(ren) in order of accessibility.

Name		Phone		Relationship	
Name		Phone		Relationship	
Name		Phone		Relationship	

Please list any allergies or medical conditions of which we should be aware:

_____

_____

Please note: Medications will not be administered during extended care.

HOMEWORK: I would like my child(ren) to participate in the homework group during extended care. Yes____ No ____

Extended Care Snack: In the event that my child does not bring a snack from home:

_____ Yes, he/she may purchase 1 snack per day from the office (depending on availability) for $1.

_____ No, he/she does not have my permission to purchase a snack from the office

_____ _____

Parent/Guardian Signature Date