



Faith West Extended Care Program

Student Information and Medical Release

Student Name: _____ Date of Birth: _____ Age _____ Grade _____

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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

_____	_____
_____	_____
_____	_____
_____	_____



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Registration Form

Registration fee of \$25.00 per child

Mother's Name _____ email address _____

Father's Name _____ email address _____

Please Circle One (extended care hours 2:45 – 6:00 pm):

Three Day - \$265

Four Day - \$350

Five Day - \$435

Fridays Only – \$450

Drop-in

(BCA students, noon – 6:00 pm)

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 _____
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