



Family Name: _____

Father: _____ Mother: _____

List each student's first and last name.

Name: _____ Grade: _____

Name: _____ Grade: _____

Name: _____ Grade: _____

Name: _____ Grade: _____

Name: _____ Grade: _____

Authorization for Emergency Treatment

I hereby authorize any physician, surgeon, dentist or hospital medical staff to administer any emergency treatment or medicine necessary or advisable when All Saints personnel accompany my child/children named above to a medical facility. I also authorize All Saints Catholic School personnel to secure the use of an ambulance, if necessary, for transporting my child/children to the hospital/medical facility. I agree that this authorization will remain in force as long as my child/children participate in the All Saints Before/After Care program, unless notified in writing of a change by me.

Preferred Doctor: _____ Preferred Hospital: _____

Parent Agreement

I, _____, agree to the following conditions involved in the care of my child/children in the All Saints Catholic School Before/After Care program.

The Before/After Care staff will exercise reasonable care and judgment in all matters related to the welfare and safety of my child/children.

In case of illness or injury, the Before/After Care staff will promptly take such reasonable measures as are, in their judgment, in the best interest of the child and will notify me as soon as possible.

The Before/After Care staff will not release my child/children to anyone other than the parent/guardian unless they have permission from the parent/guardian.

I understand that my child/children must follow all school rules and regulations and are subject to the same discipline as during regular school hours.

In return for a fee, the Before/After Care program will give regular care to my child/children from dismissal time until 6:00 P.M., if needed, on regular school days. Other arrangements must be made during school holidays.

A late fee of \$5 will begin if children are not picked up at 6:00 P.M. and \$1 for each additional 5 minute interval thereafter. The Before/After Care program is a self-supporting program and cannot "carry" any fees.

I understand that if my Before/After care balance is more than 45 days past due, my child cannot return to Before/After Care until the balance is paid in full.

Signature of Parent/Guardian: _____ Date: _____