St. Raphael's Extended Day Program
Information/Emergency Form 20____/20____

Child:_____ **Birth date:**_____ **Child :**_____**Birthdate:**_____

Child:_____**Birthdate:**_____**Child:**_____**Birthdate:**_____

Address: _____ **Telephone #:**_____

City: _____ **Zip Code:** _____

Parent/Guardian name(s): _____**Work #:**_____**Cell #**_____

_____ **Work #:** _____**Cell #**_____

Days Attending: Monday Tuesday Wednesday Thursday Friday Pick-up Time: _____

Any physical conditions/special needs that we should be aware of?* _____

Allergies: (specify child)* _____

_____

***Continue on back, if necessary.**

Persons whom you approve to pick up child (Driver's license/Photo ID required at time of pick-up).

Name:_____ Relationship: _____

Name:_____ Relationship:_____

Name:_____ _____Relationship:_____

Name:_____Relationship:_____

Emergency contact: _____ **Work #:**_____
Cell#:_____
Home #:_____

Emergency contact: _____**Work #:**_____
Cell #:_____
Home #:_____

Emergency contact: _____ **Work #:**_____
Cell#:_____
Home #:_____

Physician:_____ **Telephone #:**_____

Clinic:_____ **Telephone#:**_____

Dentist: _____ **Telephone #:** _____

In case of accident, serious illness, or ingesting of a hazardous substance, I give St. Raphael Extended Day Program personnel my permission to contact the physician or emergency hospital (911), call Poison Control, or administer syrup of ipecac, if I cannot be reached.

Parent/Guardian Signature:_____ Date:_____