

# ST. CATHERINE LABOURE SCHOOL EMERGENCY EXTENDED DAY CARE 2011-2012

For office use only:

NAME:	
Fee Paid: _____	<b>Hours: 7:00AM-8:00AM 2:30PM-6:00PM</b>
Registration fee: \$50.00	Fee per child: \$3.00/hour
	<b>LATE PICK-UP FEE \$30.00</b>

Emergencies involving children may arise at any time. It is of the utmost importance that the school have the following information for **EACH FAMILY**. It may mean the difference between life and death if an emergency or accident should occur. This information will be kept on file in the office. Notify the school immediately if any of these phone numbers change.

**IMPORTANT: Emergency numbers need to be current! Call office if numbers change.**

**PLEASE PRINT**

Family Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Home Telephone # \_\_\_\_\_ Email address \_\_\_\_\_  
 Mother's Name \_\_\_\_\_ Business # \_\_\_\_\_ Cell # \_\_\_\_\_  
 Father's Name \_\_\_\_\_ Business # \_\_\_\_\_ Cell # \_\_\_\_\_

Relative or neighbor to call in emergency:

Name \_\_\_\_\_ Telephone # \_\_\_\_\_  
 Name \_\_\_\_\_ Telephone # \_\_\_\_\_

CHILD'S NAME	BIRTH DATE	GRADE	ALLERGY, CHRONIC ILLNESS, ETC.
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If an accident occurs, I give permission for **FIRST AID** to be administered.

Check one  Yes { }  No { }

In case of serious accident the Glenview Paramedic Squad will be called immediately to administer first aid and evaluate the condition of the child, and the parents will be contacted. If hospitalization is required and if parents cannot be reached, the child will be transported by the paramedics to Glenbrook Hospital, to save time until the parents are located. If the child's condition is serious, he/she will be taken to the most medically appropriate hospital. NOTE: The Paramedics do not service hospitals other than the one listed above.

As a parent and/or legal guardian I authorize the treatment of the minors listed on this form by a qualified and licensed medical doctor in the event of a medical emergency, which in the opinion of the attending physician may endanger his/her life, cause physical liability or undue discomfort if delayed. This consent is granted only after a reasonable effort has been made to reach me.

I anticipate using the program (x appropriate sections).

- { } Morning before school { } Each afternoon after school { } To be determined weekly  
 { } Occasionally before school { } Occasionally after school { } Other

Person(s) who will ordinarily pick up child(ren).

Name \_\_\_\_\_ Phone # \_\_\_\_\_  
 Name \_\_\_\_\_ Phone # \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

(This is to be filled out if you want Extended Care)

