ST. VINCENT DE PAUL
CATHOLIC SCHOOL

CARE SIGN UP FORM

* Required Information

***Father's Name:** _____
*Address: _____
City: _____ State: _____ Zip Code: _____
Phone: *cell: _____ home: _____ work: _____

***Mother's Name:** _____
*Address: _____
City: _____ State: _____ Zip Code: _____
Phone: *cell: _____ home: _____ work: _____

***Physician's Name:** _____
* Phone Number (including area code): _____
*Preferred Hospital: _____
*Insurance: _____

Child's Name: _____
Grade: _____
Medical Conditions/Allergies: _____

Child's Name: _____
Grade: _____
Medical Conditions/Allergies: _____

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Grade: _____
Medical Conditions/Allergies: _____

Child's Name: _____
Grade: _____
Medical Conditions/Allergies: _____

I am requesting: ☐ Before Care ☐ After Care ☐ Before and After Care

I authorize the following people to pick up my child/ren if I am unavailable.
Note: authorized people should be prepared to show identification.

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

I authorize supervisory personnel at St. Vincent de Paul School's Care Program to provide necessary emergency care and services in the treatment of sudden illness or injury to my child/ren if I cannot be contacted by phone.

☐ *I agree to the above waiver

*Parent/Guardian Signature: _____ Date: _____