ST. VINCENT DE PAUL CATHOLIC SCHOOL

CARE REGISTRATION 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: _____

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Medical Conditions/Allergies: _____

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Medical Conditions/Allergies: _____

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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 Catholic 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: _____