Holy Disciples Catholic School

The **Before Care Extension Program** takes place at each campus - 7am-start of school.
Grades PK-4 - Holy Disciples Elementary Campus - 140 Buckingham Street, Oakville, CT 06779 860-945-0621
Grades 5-8 - Holy Disciples Middle School Campus - 760 Main Street, Watertown, CT 06795 860-274-9208

The **After Care Extension Program** takes place at the Holy Disciples Elementary Campus*- dismissal to 6pm.
**students at the Middle School Campus registering for After Care will take a school bus to the Elementary School Campus to attend the After Care program*

EXTENSION PROGRAM FAMILY REGISTRATION FORM

Completing this form registers your child/ren for both Extension Programs

Child's Name _____ Birthdate_____ Grade _____
Child's Name _____ Birthdate_____ Grade _____
Child's Name _____ Birthdate_____ Grade _____

STUDENT EMERGENCY DATA

PARENT / GUARDIAN NAME	PHONE	EMAIL

List 2 adults who will assume temporary care of your child/ren if you cannot be reached.

ADDITIONAL CONTACT	RELATIONSHIP	PHONE (preferably cell)	EMAIL

In an emergency, if none of the above persons can be contacted, the extended care manager/administrator will call 911.

I understand that in the final disposition of an emergency, the judgment of the school authorities will prevail. If any of the above information must be changed, I will notify the Principal where my child attends school in writing.

Child/ren's Doctor: _____ Phone: _____
Child/ren's Dentist: _____Phone: _____

Allergies and/or Health Concerns:_____
Please complete the Special Instructions section to provide details about symptoms and treatment.

I/We abide by the agreement I/We have read in the Extension Program Handbook and understand the fees, guidelines, arrival and pick-up procedures.

PARENT/GUARDIAN SIGNATURE: _____ **Date:** _____

PARENT/GUARDIAN SIGNATURE: _____ **Date** _____

SPECIAL INSTRUCTIONS

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FOR MINOR CHILD

ALLERGIES/OTHER MEDICAL CONDITIONS

CHILD'S NAME: _____

Please list: _____

Special Instructions: What symptoms might your child exhibit? _____

Requested actions to be taken by staff – Please Specify: _____

Emergencies: I/we hereby give my/our consent to the Extension Care Program Director or any authorized official at the Holy Disciples Catholic School in the event all reasonable attempts to contact me/us, to provide treatment deemed necessary by our child/ren's physician/healthcare provider or in the event that the physician/healthcare provider is not available, by other licensed physician or dentist or emergency medical personnel.

In the event of a medical emergency requiring immediate medical attention, I/we give permission for medical assistance to be given to my/our child. Furthermore, if I/we cannot be reached and emergency care is needed, I/we give permission for the responsible person at the Extension Care Program to make arrangements for my/our child to be transported to the nearest hospital emergency room. The hospital has my/our authority to provide my/our child all medical care they deem necessary and I/we agree to be financially responsible for any and all care given.

Behavior Requirement: Class and in-school rules are followed in the Extension Care Program in order to ensure the physical and emotional safety of each participant, as well as the physical and emotional safety of the Extension Care Manager and other staff, and for the protection of school property. Students are expected to know, and be willing and able to exhibit appropriate classroom behaviors. The Holy Disciples Catholic School reserves the right to dismiss any participant they deem unwilling or unable to do so, without refund.

PARENT SIGNATURE: _____ **Date:** _____

PARENT SIGNATURE: _____ **Date:** _____