Queen of Angels After-School Program Registration

Queen of Angels Catholic School

Please complete and return prior to attendance in the program.
A $25 non-fundable registration fee per family must be submitted along with registration. Make checks payable to Queen of Angels Catholic School.

Family Name:_____

Address: _____

Participation in the program will be: ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri
☐ 4:30 pickup ☐ 5:30 pickup

For each child, please give name, grade, and birthdate

First Name: _____ Grade: _____ Birthdate: _____

First Name: _____ Grade: _____ Birthdate: _____

First Name: _____ Grade: _____ Birthdate: _____

Parents:

Mother's Name _____ Cell # _____ Home # _____

Employer _____ Work Phone _____

Father's Name _____ Cell # _____ Home # _____

Employer _____ Work Phone _____

Emergency Contact:

Name _____ Home Phone _____

Relationship _____ Cell Phone _____

Persons authorized for student dismissal other than parent:

Name _____ Home Phone _____

Relationship _____ Cell Phone _____

Name _____ Home Phone _____

Relationship _____ Cell Phone _____

Medical Information

Please list all allergies and medical conditions for each child:

In the event of a medical emergency, I authorize school personnel to seek medical care for my child.

Parent signature: _____
Preferred Hospital: _____

Insurance Information:

Medical Insurer: _____

Policy # _____

Agreement/Group # _____

I have read and agree to all the terms provided in the Queen of Angels After School Program Handbook. I agree to the financial responsibilities set forth in enrolling my child in the program.

Parent Signature:_____ Date: _____

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Office Use:

Date: _____ Registration Fee Paid _____ Check # _____