TO BE COMPLETED BY ALL FAMILIES

ST. PAUL THE APOSTLE SCHOOL
EXTENDED DAY STUDENT INFORMATION

List each student in your family:

_____ Grade_____Date of Birth_____ Age_____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____
HOME ADDRESS CITY, STATE, ZIP HOME PHONE #

_____ _____
MOTHER'S NAME MOTHER'S BUSINESS PHONE #

_____
MOTHER'S CELL PHONE #

_____ _____
FATHER'S NAME FATHER'S BUSINESS PHONE #

_____
FATHER'S CELL PHONE #

Person(s) who have permission to pick up student other than parents:

_____ _____
NAME HOME PHONE #

_____ _____
RELATIONSHIP TO STUDENT BUSINESS PHONE #

_____ _____
NAME HOME PHONE #

_____ _____
RELATIONSHIP TO STUDENT BUSINESS PHONE #

EMERGENCY INFORMATION:
The school will make every effort possible to contact a parent at work or at home before seeking emergency treatment. In the event of emergency, if you cannot be reached , do you authorize the school to give consent for medical treatment for the above child(ren)?_____YES _____NO
If no, what procedure should be taken?_____
_____

Allergies to food, milk, etc.? Yes_____No_____Child's Name_____
Yes_____No_____Child's Name_____
Yes_____No_____Child's Name_____
Yes_____No_____Child's Name_____

What is child(ren) allergic to?_____

_____

_____ _____
PARENTS SIGNATURE DATE