

**Cathedral School Extended Care  
Registration Form  
2015-2016 Academic Year**

Student's Legal Name Last, First Middle	Nick name (if applicable)	Sex M/F	Birth Date	Grade	Publicity
					Yes/No
					Yes/No
					Yes/No

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**Parent/Guardian Information**

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Last Name	First	Relationship to Student	Home Phone
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Address	City	State	Zip
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Employer	Work Phone	Cellular
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E-mail Address

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Last Name	First	Relationship to Student	Home Phone
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Address	City	State	Zip
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Employer	Work Phone	Cellular
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E-mail Address

Parent/Guardian Status (circle one)    Married / Single / Divorced / Legally Separated / Widowed

Custodial Rights (circle one)            Both / Mother / Father / Guardian / Other

List all persons who are authorized to pick up your child/ren from Extended Care

Person authorized to pick up	Phone Number	Relationship to Child

List all food allergies:

Child's Name: \_\_\_\_\_ Allergies: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Allergies: \_\_\_\_\_

Additional allergies, information or concerns:

Child's Name: \_\_\_\_\_ Information: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Information: \_\_\_\_\_

An Authorization for Medication form must be completed for any prescription/non-prescription medication. Lifesaving medication i.e. Epi-pens & Inhalers need to be checked into the school office and a set for both school and extended care provided. Medication must be transported to and from Extended Care by an adult.

**\*\*\*Please be aware that we have students with severe peanut allergies\*\*\***

Physician's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Medical Plan: \_\_\_\_\_ Policy # \_\_\_\_\_ Member #: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

In case of serious accident, 911 and the parents will be called simultaneously. In case of an emergency when a parents or guardian cannot be reached, I give permission to Cathedral School to contact and send the above named child/ren to the persons listed below, or in necessary, to the doctor and/or hospital indicated. I assume full responsibility if my child/ren needs medical attention and assume any ambulance and medical expenses. I also give permission for Cathedral School personnel to administer CPR and/or first aid if deemed necessary.

In case of emergency if parents cannot be reached, please list at least 2 relatives or friends that we may call:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

IN ORDER TO COMPLY WITH STATE REGULATIONS ALL INFORMATION ON THIS MEDICAL EMERGENCY FORM MUST BE FULLY COMPLETED.

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date