



**EXTENDED DAY PROGRAM**

**REGISTRATION FORM 2023 TO 2024**

Name: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Grade: \_\_\_\_\_

Student Lives With: \_\_\_\_\_ both parents \_\_\_\_\_ mother \_\_\_\_\_ father \_\_\_\_\_ other

Father's Name: \_\_\_\_\_

Father's Place of Business: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Mother's Place of Business: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Primary Phone:** \_\_\_\_\_ (to be used to contact parents in a non-emergency situation)

**Primary Email Address:** \_\_\_\_\_

(This is the email address that will primarily be used to contact the Extended Care Program – the one that the Extended Care Program should use if we need to contact you.)

**EXTENDED DAY USAGE**

Please check the days and time that you expect to utilize the Extended Care Program for the school year.

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY		DROP-IN ONLY
AM 7:00-8:10am							
PM 2:25-5:30pm							

I agree to abide by all the rules and regulations of the Holy Trinity School Extended Care Program. I understand that Extended Care fees are collected separately from my tuition payments, and I am responsible for paying the fees on a monthly basis.

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PICKUP INFORMATION for \_\_\_\_\_ (child's name)**

Please list the individuals who may pick up your child from the afternoon Extended Care Program. A photo ID may be required for pickup.

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**EMERGENCY INFORMATION for \_\_\_\_\_ (child's name)**

Please list the numbers that you would like us to call in an emergency. Please include parents' phone numbers to call in an emergency as well.

1. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

2. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

3. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

4. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Please list any medical conditions or allergies that your child has:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List of medications that your child is currently taking:

\_\_\_\_\_

Child's physician: \_\_\_\_\_ Phone: \_\_\_\_\_