SACRED HEART SCHOOL

RELIGION ♥ ACADEMICS ♥ ATHLETICS

EXTENDED CARE PROGRAM AGREEMENT

STUDENT NAME #1: _____ **#1 GRADE:** _____

STUDENT NAME #2: _____ **#2 GRADE:** _____

STUDENT NAME #3: _____ **#3 GRADE:** _____

STUDENT NAME #4: _____ **#4 GRADE:** _____

STUDENT NAME #5: _____ **#5 GRADE:** _____

The children will be in (check all that apply):

☐ MORNING CARE

☐ AFTERNOON CARE

Will you be using Extended Care regularly? _____

PARENT'S NAME: _____ **PHONE:** _____

ADDRESS: _____ **EMAIL:** _____

Persons Authorized to Pickup Child/Children / Emergency Contacts:

NAME: _____ **RELATIONSHIP:** _____ **PHONE:** _____

NAME: _____ **RELATIONSHIP:** _____ **PHONE:** _____

NAME: _____ **RELATIONSHIP:** _____ **PHONE:** _____

Primary Physician: _____ **PHONE:** _____

Do any of the children have:

☐ Dietary Restrictions? ☐ Allergies?

☐ Restrictions on activity?

☐ Please specify: _____

I hereby authorize Sacred Heart School to obtain emergency medical treatment for my child if I cannot be reached. Emergency medical treatment will be obtained by calling 911.

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Signature of Parent/Legal Guardian Date