



**SAINT JOAN OF ARC SCHOOL
BEFORE/AFTER CARE
PROGRAM (BAC)
2011-2012 REGISTRATION FORM**



HEALTH HISTORY (Must be fully completed for each child)

Please provide the following information about (child's name and homeroom)_____:

Child's Doctor's Name _____ Phone _____
Child's Dentist's Name _____ Phone _____

Allergies (Please check all that apply or NONE): Hay Fever _____ Antibiotic (type) _____
Drugs (type) _____ Poison Ivy _____ Other Plants _____
Insect Stings _____

Food Allergy[please name the food(s)] _____ NONE _____
Other _____

Does child require an Epi Pen? _____

Please tell us what we need to know about your child's allergy(ies): _____

Operations or Serious Injuries:

Date of Injury/Surgery: _____ Type of Injury/Surgery _____

Date of Injury/Surgery: _____ Type of Injury/Surgery _____

Disability or Chronic/Recurring Illness _____

Specific Activities to be Encouraged/Limited by Physician's Advice _____

EMERGENCY PERMISSION SLIP

There is always a possibility that child may be injured or become seriously ill during the BEFORE/AFTER SCHOOL PROGRAM and that we may not be able to contact the parents. **Medical aid cannot be given to a child without his/her parent's consent.** In an emergency, time can be vital. Your signature on this permission slip, which is kept on file at SJA BAC, will allow for medical aid in case such an emergency occurs and we are unable to reach you immediately.

I give permission for my child _____, grade _____, to be transported to a Hospital Emergency Room for medical aid in the case of extreme emergency, provided I cannot be contacted when the emergency occurs.

HOSPITAL PREFERENCE: _____

Please indicate which parent should be called first in an emergency: Mother _____ Father _____

Father's Signature _____ Date _____

Mother's Signature _____ Date _____

**Please notify SJA BAC, in writing, of any change of information given on this form as soon as possible.
Thank You!**



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FAMILY NAME: _____
OF CHILDREN: _____



Child's Name _____

****A separate form is to be fully completed for each school student in the family.**

Home Address _____

City, State _____ Zip _____ Home Phone _____

Date of Birth / / Grade for 2011-2012 _____
 M D Y

Father's Name _____ Work # _____ Cell # _____

Place of Employment _____
(Name of business and street address)

Mother's Name _____ Work # _____ Cell # _____

Place of Employment _____
(Name of business and street address)

E-mail Address: _____
(Address that is viewed the most by either parent if communication is necessary)

Martial Status of Parents: Married _____ Separated _____ Divorced _____
If separated or divorced, who does the child live with primarily? Mother _____ Father _____
If there are restrictions on either parent or other adult regarding the child, please explain:

AUTHORIZATION FOR PICK-UP OF CHILD FROM SJA BAC – Give names of three reliable adults to contact, in case of emergency, if neither parent can be reached:

Name _____ Phone _____ Cell _____ Relationship to child _____

Name _____ Phone _____ Cell _____ Relationship to child _____

Name _____ Phone _____ Cell _____ Relationship to child _____

Circle Days of Week Needed: All days Monday Tuesday Wednesday Thursday Friday

I will be a regular participant _____ I will be an occasional participant _____

Before and After Care _____ After Care Only _____ Before Care Only _____

\$25.00 Registration Fee - Per FAMILY is due with this form