

Divine Mercy Catholic School Age Childcare

For Office Use Only:

_____ Paid Registration _____ Check # _____ Cash _____ Date

Family Last Name _____ Home Phone _____

Address _____ City & Zip _____

Mother's Place of Employment _____

Work Phone _____ Cell _____

Father's Place of Employment _____

Work Phone _____ Cell _____

Child is in the custody of: ☐ Mother ☐ Father ☐ Both Parents ☐ Other

Child's Name: _____ Homeroom: _____ Birth date: _____

Child's Name: _____ Homeroom: _____ Birth date: _____

Child's Name: _____ Homeroom: _____ Birth date: _____

Persons who can be contacted in an emergency and assume responsibility for child/ren if the parent cannot be reached. These individuals are also authorized to pick up the child/ren. (Please note validation of identity will be required, driver's license, etc.)

Name _____ Phone _____

Relation to Child _____

Name _____ Phone _____

Relation to Child _____

Name _____ Phone _____

Relation to Child _____

PLEASE FILL OUT BACK SIDE

Physician/Clinic Name _____ Phone _____ Address

_____ Hospital _____

Dentist/Clinic Name _____ Phone _____ Address

_____ Hospital _____

List any medical conditions that Latchkey Staff will need to be aware of, e.g. allergies, asthma, etc.

Child's Name _____

Condition:

Child's Name _____

Condition:

Child's Name _____

Condition:

I understand that fees are due as stated per agreement. I understand that it is my responsibility to immediately report any changes to the information provided above.

Signature _____