

St. Stanislaus School
534 Front St.
Chicopee, MA 01013
REGISTRATION
AFTER SCHOOL PROGRAM

Student Name _____ Grade _____

Students' address _____

_____ Home Phone _____

Parent/ Legal Guardian _____

Phone number where parent can be reached during the hours of the After School Program

NAMES OF PERSONS AUTHORIZED TO PICK-UP STUDENT

Name	relationship to student	Telephone #
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Name	relationship to student	Telephone #
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Please indicate which days your child will be attending the program by circling the appropriate days below.

Monday Tuesday Wednesday Thursday Friday As needed

HOMEWORK RESPONSE FORM

_____ My child may choose whether to do homework.

_____ My child must complete as much of his/her homework as possible.

_____ My child should not do homework.

EMERGENCY MEDICAL INFORMATION

In the event of illness or injury to my child, which in the judgment of the After School Program staff requires emergency treatment, my permission is granted to call the following doctors in order named, after attempts to contact me by telephone have been unsuccessful.

Doctor _____

Doctor _____

Address _____

Address _____

Telephone _____

Telephone _____

The hospital emergency room of my choice is _____

My Child is allergic to the following:

Medications _____

Foods _____

Other _____

I hereby release St. Stanislaus School from any claim arising out of the doctor's actions. All medical expenses shall be the parent responsibility.

Parent/Guardian Signature _____

Address _____

Home Phone _____ Business/work Phone _____

EMERGENCY CONTACTS

Please give the name and phone number of two people who may be contacted in case of emergency or illness when the parent or guardian is not available. These people should live in the vicinity of the school and be able to be contacted during the hours the program is in operation.

Name _____

Name _____

Telephone _____

Telephone _____