ST. CATHERINE OF SIENA SCHOOL
EXTENDED AFTER SCHOOL CARE MEDICAL FORM
2016-2017

Child's Last Name _____ First Name _____ Birth Date _____

Address _____ Grade _____

City _____ Zip _____ Telephone Number _____

Mother/Guardian _____ Cell phone # _____ Work Phone Number _____

Father/Guardian _____ Cell Phone # _____ Work Phone Number _____

In the event of an apparent serious illness or accident when I/we cannot be reached, I/we wish one of the following persons to be notified by telephone. The following persons are also authorized to pick up our child in the event we cannot do so.

1. Name _____ Relationship _____

   Address _____ Cell Phone _____Phone_____

2. Name _____ Relationship _____

   Address _____ Cell Phone _____Phone_____

3. Name _____ Relationship_____

   Address _____ Cell Phone _____Phone_____

In the case of an emergency when I or my emergency contacts cannot be reached, I give my permission to obtain or administer whatever medical services should be necessary.
I also agree to inform the Extended After School Care Coordinator in writing should my child be on medication anytime during the year.

_____
Parent/Guardian

Physician Name _____ Telephone Number _____

Dentist Name _____ Telephone Number _____

Hospital Preference _____