**ST. CATHERINE OF SIENA SCHOOL**
**EXTENDED AFTER SCHOOL CARE MEDICAL FORM**
**2020-2021**

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 _____