

St. Xavier Catholic School  
After Care Program  
Enrollment Form

Name of Child(ren)	Grade	Birthday	Days of Attendance
_____	_____	_____	M T W Th F
_____	_____	_____	M T W Th F
_____	_____	_____	M T W Th F
_____	_____	_____	M T W Th F

Parent(s) / Guardian(s) with whom child(ren) resides:

_____	_____	_____
Name	Address	Phone
_____	_____	_____
Name	Address	Phone
_____	_____	_____
Name	Address	Phone

Persons authorized to pick up child(ren) / **Emergency Numbers** ( people that can be reached **DURING** program hours ) Only those listed below will be allowed.

_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone

Child(ren)'s Physician:

_____	_____	_____
Name	Address	Phone

Emergency Medical Release:

If emergency medical care is deemed by the St. Xavier Catholic Schools Aftercare Program to be necessary and I can't be contacted, I authorize Aftercare Program Staff or St. Xavier Staff to act in my behalf in seeking emergency medical treatment for my child(ren).

_____	_____	_____
Health Insurance Provider	Policy#	Group
_____	_____	
Parent/Guardian Signature	Date	