

Aquinas Academy After-Day Program Registration Form

Please complete and return this form prior to attendance at the program. A non-refundable \$25 registration fee per family must be submitted along with the registration form.

Family Last Name: _____

Home Address: _____

Participation in the program will be: _____ days per week; _____ occasional

For each child, please give name, grade, and birthdate

First Name: _____ Grade: _____ Birthdate: _____

First Name: _____ Grade: _____ Birthdate: _____

First Name: _____ Grade: _____ Birthdate: _____

Parents:

Mother's Name _____ Cell # _____ Home # _____

Employer _____ Work Phone _____

Father's Name _____ Cell # _____ Home # _____

Employer _____ Work Phone _____

Emergency Contact:

Name _____ Home Phone _____

Relationship _____ Cell Phone _____

Persons authorized for student dismissal other than parent:

Name _____ Home Phone _____

Relationship _____ Cell Phone _____

Name _____ Home Phone _____

Relationship _____ Cell Phone _____

Medical Information

Please indicate any allergies or medical conditions for your child:

In the event of an emergency, I authorize school personnel to seek emergency treatment at an emergency room. UPMC Passavant Hospital is the closest emergency department. It will be used unless the parent requests a different hospital location.

Parent signature: _____

Preferred Hospital: _____

Insurance Information:

Medical Insurer: _____

Policy # _____

Agreement/Group # _____

I have read and agree to all the terms provided in the Aquinas Academy After-Day Program Handbook. I agree to the financial responsibilities set forth in enrolling my child in the program for either occasional or regular attendance.

Parent Signature: _____ **Date:** _____

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Office Use:

Date: _____ **Registration Fee Paid** _____ **Check #** _____