

St. Joseph School Summer Program

Registration Form

Summer 2019

Family's Name: _____

Child's Name	Grade	Weeks Attending (please circle) Do not indicated Vacation Bible School.
		1 2 3 4 5
		1 2 3 4 5
		1 2 3 4 5

Are you interested in an After Care option? **Yes or No**

Primary Parent/Guardian Information:

Name(s): _____

Home Address: _____

Cell Phone: _____ Work Phone: _____

Home Phone: _____ Email: _____

Alternative Emergency Contacts:

Name (Relationship): _____ Phone #: _____

Allowed to Pick Up After Program? Y or N

Name (Relationship): _____ Phone #: _____

Allowed to Pick Up After Program? Y or N

Name (Relationship): _____ Phone #: _____

Allowed to Pick Up After Program? Y or N

Child(ren) Insurance:

Health Care Provider: _____

Contact Information: _____

Does your child have Health Insurance? Yes _____ No _____

If yes, provider of insurance: _____

Medication:

Is your child taking any medications? Yes _____ No _____

If yes, names of medication: _____

Allergies:

1. Please list any medication allergies and symptoms: _____

2. Please list any food allergies and symptoms: _____

Food allergy requires use of EpiPen? Yes _____ No _____ Benadryl? Yes _____ No _____

3. Severe Bee Sting Allergy? Yes _____ No _____

Requires use of EpiPen? Yes _____ No _____ Benadryl? Yes _____ No _____

Other Medical Concerns:

Asthma: Yes _____ No _____

If yes, Mild _____ Moderate _____ Severe _____ Exercise Induced _____

Date of Last Episode: _____ Asthma Medication Required? Yes _____ No _____

Seizures: Yes _____ No _____ If yes, date of last seizure: _____ Type: _____

Diabetes: Yes _____ No _____ If yes, use of insulin pump _____, pen _____, injection _____, or other _____?

Other Special Medical Needs/Considerations?

Please initial next to each if you agree with the following:

_____ I agree that ALL of the Registration Form (pages 2 & 3) has been completed to the best of my knowledge.

_____ I acknowledge that my child(ren) has an up-to-date physical, as appropriate, on file with St. Joseph School Health Office.

_____ I agree for my child(ren) to be photographed or recorded during the Summer Program, which may appear on the school's social media and/or website.

_____ I agree to inform the Summer Program immediately if any of the above information changes throughout the summer.

_____ I hereby warrant that to the best of my knowledge, my child(ren) is in good health, and I assume responsibility for the health of my child(ren), and for the cost and expense of any medical treatment should such become necessary while my child(ren) is participating in the Summer Program.

_____ I hereby give my consent to St. Joseph School staff to give necessary first aid to my child(ren).

_____ I hereby give my consent to the person in charge at St. Joseph School to obtain and consent to, on my behalf, whatever medical diagnosis treatment is deemed necessary or advisable by such person for the well-being of my child (ren).

_____ I hereby give consent, in the event of injury or illness, for emergency medical treatment, hospitalization, and/or other medical treatment as may be necessary for the welfare of my child(ren) by a physician, qualified nurse, and/or hospital or health care facility while my child(ren) is participating in the Summer Program.

_____ Further, I hereby release and discharge St. Joseph School employees, chaperones, and/or volunteers from any and all liability arising out of such medical treatment.

Medication:

If your child needs medication administered WHILE attending the Summer Program, we will need all medication BEFORE he or she can start the program. All medications need to be in their original boxes (unopened) with a copy of a recent doctor's order.

Parent/Guardian Print: _____

Signature: _____ **Date:** _____