

St. Joseph Catholic School
After School Care (ASC) Registration Form
2017-2018

Student's Name: Last: _____ First: _____

Grade: _____ Date of Birth: _____ Age: _____

Home Phone: _____ Address: _____

Mother/Guardian Name: _____ Cell Phone: _____

Place of Employment: _____ Work Phone: _____

Father/Guardian Name: _____ Cell Phone: _____

Place of Employment: _____ Work Phone: _____

Emergency Contacts: When I cannot be reached, please contact the following person(s). They have permission to pick up/make emergency decisions for my child.

1. Name: _____ Relationship to student: _____

Work Number: _____ Cell Phone: _____

2. Name: _____ Relationship to student: _____

Work Number: _____ Cell Phone: _____

3. Name: _____ Relationship to student: _____

Work Number: _____ Cell Phone: _____

Doctor's Name: _____ Phone: _____

Insurance Provider: _____ Policy Number: _____

Allergies or Medical Conditions: _____

Medications Needed: _____

Please anyone that **DOES NOT** have permission to pick up your child: _____

- Billing Preference form (attached) must be filled out and returned in order for your child to attend the program.
- ASC **WILL NOT** be available on days that the school is closed or on early release days.

Agreement and Release Form

I hereby release St. Joseph Catholic School/Church and the Catholic Diocese of Austin and their representatives from any liability, loss, damage, costs, claims, and/or causes of action, including but not limited to all bodily injuries and property damage arising from my child _____ participating in the After School Care Program. I further give permission for the Director and/or staff of the St. Joseph Catholic School After School Care Program to authorize medical treatment on my behalf in the event of a medical emergency when I cannot be reached. I understand every effort will be made to contact me, or the emergency contacts I have listed above, should an emergency arise.

I understand there is a late fee if my child is not picked up on time and a drop in fee if my child uses the services of the After School Care Program on an as needed basis.

Signature of Parent/Guardian: _____ Date: _____

**St. Joseph Catholic School
After School Care
Billing Preference
2017-2018**

Students Enrolled in the After School Care Program:

- Student 1 – Name: _____ Grade: _____
- Student 2 – Name: _____ Grade: _____
- Student 3 – Name: _____ Grade: _____

Parent/Guardian Name: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

Permanent Address:

Person responsible for ASC charges:

Parent/Guardian Name: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

Mailing Address for Billing:

I wished to be billed:

_____ I will sign up on FACTS for an annual plan of \$720 per year per child

_____ one payment due August 25, 2017 of \$720.00 each per child

_____ two payments due on August 25, 2017 and January 5, 2018 of \$360.00 each per child

_____ I will sign up on FACTS for a monthly plan of \$80 per month per child to be paid in 9 payments beginning with my September FACTS payment

Drop In Use:

_____ I wish to pay as a drop-in whenever my child uses the ASC program, I will pay the elementary school Administrative office \$15 per day when I use the service.

Agreement

I, _____, understand that payments for the After School Program are in addition to the monthly tuition and must be paid through FACTS. I agree to inform the school in writing using this form if my child stops attending the ASC program or I wish to change my billing preference. Until such time, I understand that I will be billed according to my preferences noted above.

Signature of Parent/Guardian: _____ Date: _____