

**QUEEN OF ANGELS CATHOLIC SCHOOL
EXTENDED DAY PROGRAM PARENTAL AGREEMENT**

I understand that I am enrolling my child/ren

Name of Child(ren)

in the Queen of Angels Catholic School Extended Day Program for the 2009-2010 school year. She/he will attend: *(check each day that applies)*

Mondays _____ I will send notes

Tuesdays _____

Wednesdays _____

Thursdays _____

Fridays _____

I understand that the Extended Day Program is open according to the official school calendar of Queen of Angels Catholic School, and is closed during vacations, teacher workdays, Labor Day, Thanksgiving and Christmas Noon Holidays, last day of school, and inclement weather days.

1. I will update my child's file information as outlined in the Parent Handbook. I acknowledge that it is my responsibility to keep the center advised of significant changes as the changes occur in the information that was provided at the time of enrollment concerning phone numbers, work locations, emergency contacts, family physician, etc.
2. The Program Staff will assume full responsibility for my child from the time he/she arrives at the Program until my child leaves the Program according to the written instructions for departure. A snack will be provided according to the menu posted.
3. I understand that my child will not be allowed to leave the facility without being escorted by the parent(s), person authorized by parent(s), or facility personnel. If it is necessary for someone other than the parent / guardian to pick up the child, I will contact the staff in charge of Extended Day Program to specify that person or persons not previously specified on the form to pick up my child and I understand that identification to establish identity before my child may be released to the parent's / guardian's designee.
4. If medical emergency arises, the Program staff will first attempt to contact me. If I cannot be reached, the staff will try to contact my child's doctor and the person(s) I have listed as my child's emergency contacts. If the emergency is such that immediate hospital attention is necessary, an ambulance or emergency vehicle may take my child to the hospital.
5. I agree to adhere to the policies and procedures of the Extended Day Program as stated here and in the Parent/Student Handbook, and give my child permission to participate fully in this program.
6. The facility agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, or exposure to communicable disease, which include my child.
7. Medication will not be dispensed during EDP hours except in cases of emergency. A Medication Permit Form must be completed in order for medication to be dispensed.

DATE: _____

SIGNATURE: _____

RELATIONSHIP TO CHILD: _____ PRINT NAME: _____

By August 31, 2009 (or first day used), submit completed enrollment forms to:

Program Director
Queen of Angels Catholic School Extended Day Program
11340 Woodstock Road
Roswell, GA 300

QUEEN OF ANGELS CATHOLIC SCHOOL
Extended Day Program Enrollment Form

Child's full name _____
Name child goes by _____ Date of Birth _____ Sex _____
Child's home address _____
_____ Child's Phone # (____) _____

PARENT OR GUARDIAN INFORMATION

Father's/Guardian 1's name _____ Phone # (____) _____
Father's address _____
Father's occupation and address of employment _____

Father's Work Phone # (____) _____ Cell (____) _____ Pager (____) _____

Mother's/Guardian 2's name _____ Phone # (____) _____
Mother's address _____
Mother's occupation and address of employment _____

Mother's Work Phone # (____) _____ Cell (____) _____ Pager (____) _____

FAMILY INFORMATION

Child resides with: ___ both parents ___ mother ___ father ___ grandparents ___ other (please list)
Brothers and/or sisters (please indicate ages and whether they live with the child)

Please list any other persons living with the child and their relationship (if any) to the child:

PICK UP – I.D. MUST BE PRESENTED

Persons authorized to pick up child:

Name _____ **Address (complete street address, city, state, zip code)** _____ **Phone** _____

Custody Restraints/Persons who may **NOT** pick up child:

- A. Name: _____
Relationship to Child: _____
- B. Name: _____
Relationship to Child: _____
- C. Name: _____
Relationship to Child: _____

Persons to contact in case of an emergency when parents cannot be reached:

Name _____ Telephone number _____

QUEEN OF ANGELS CATHOLIC SCHOOL
Extended Day Program Physical & Health Form

CHILD'S FULL NAME

BIRTH DATE

PHYSICAL ASSESSMENT

Is there any condition of vision, hearing or speech of which the childcare program should be aware?

Is this child subject to any conditions which limit participation in outdoor and indoor activities?

Is this child subject to any condition which may result in emergency situation?

Are immunizations up to date? _____ Yes _____ No. If NO, what is needed?

Immunizations are required; please see Parent/Student Handbook.

Significant Illnesses and Surgeries child has had (give age at time): _____

Any special health related needs of child (allergies, medications, injuries, or other physical problems, mental health disorders, or developmental disabilities which would limit the child's participation in the center's programs and activities.):

DATE

Signature of Parent/Guardian

EMERGENCY MEDICAL AUTHORIZATION
Queen of Angels Catholic School Extended Day Program

Child's Name: _____ Date: _____
Child's Physician: _____ Phone: _____
Address: _____ City/State/Zip: _____
Child's Dentist: _____ Phone: _____
Address: _____ City/State/Zip: _____

Authorized Adults

In the event of an emergency, please indicate your name and phone number where you and another authorized person can be reached.

Father's Name _____ Work Phone _____
Beeper/Cell _____
Home Phone _____

Mother's Name _____ Work Phone _____
Beeper/Cell _____
Home Phone _____

FIRST AID

In the event of emergency, I authorize the staff to provide any first aid care deemed necessary for my child.

Signature

PARENTAL EMERGENCY MEDICAL CONSENT

This form must be presented upon admission for treatment.

Child's full name: _____ Birth date: _____

In the event that my child (listed above) suffers an injury or illness while in the care of Queen of Angels Catholic School Extended Day Program and the facility is unable to contact me/us immediately, it shall be authorized to secure such medical attention and care for my child as may be necessary. I/We agree to keep the facility informed of changes in telephone numbers, etc. where I can be reached. I agree to pay all costs and fees contingent on any emergency medical care and/or treatment for my child as secured or authorized under this consent.

The facility agrees to keep me informed of any incidents requiring professional medical attention involving my child.

Signature

Date