St. Peter School
Extended Day Program

Name of Student _____ Date of Birth _____
Last First Middle

Address _____ Phone _____
Street City Zip

Parent/Guardians:

Name _____ Relationship to Student _____
Cell Phone _____ Work Phone _____

Name _____ Relationship to Student _____
Cell Phone _____ Work Phone _____

Does the student have any medical conditions/allergies? _____
If yes, please describe: _____
_____

Does the student take any medication? _____
If yes, please describe: _____
If medical attention is needed and the parent cannot be reached, the school will contact 911 and the child will be taken to the appropriate hospital.

Please list the names of any people who have permission to pick your child up from the Extended Day Program:

Name _____ Relationship _____
Address _____ Phone Number _____

Name _____ Relationship _____
Address _____ Phone Number _____

Name _____ Relationship _____
Address _____ Phone Number _____

_____
SIGNATURE OF PARENT/GUARDIAN