

St. Ann's School  
27 Erie Avenue  
Hornell, NY 14843-1909

2007-2008  
Extended Care Registration Form

LIST NAME, DATE OF BIRTH & GRADE (as of 9/04) OF CHILD(REN) WHO WILL BE ATTENDING:

NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_ GRADE: \_\_\_\_\_

NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_ GRADE: \_\_\_\_\_

NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_ GRADE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

FATHER'S/GUARDIAN'S NAME: \_\_\_\_\_

WORKPLACE NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ALTERNATE PHONE: \_\_\_\_\_

MOTHER'S/GUARDIAN'S NAME: \_\_\_\_\_

WORKPLACE NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ALTERNATE PHONE: \_\_\_\_\_

IN ADDITION TO PARENTS, ONE OTHER PERSON MAY BE AUTHORIZED TO PICK UP CHILD(REN):

NAME \_\_\_\_\_ PHONE: \_\_\_\_\_

PLEASE CIRCLE DAYS AND INDICATE APPROXIMATE PICK-UP TIMES

MONDAY    TUESDAY    WEDNESDAY    THURSDAY    FRIDAY

PICK-UP TIME: \_\_\_\_\_

(OVER)

**In case of emergency please contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please read the following statement and sign below:

I understand that if the information given changes, I will send a note of authorization with my child(ren). I also understand that in order to keep my child(ren) in the program, payment must be made weekly by check payable to St. Ann's School OR in cash, exact amount only.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_