St Vincent de Paul School

Print Child's Last Name:

Office Use Only:

PRESCHOOL EXTENDED CARE PROGRAM (PSEC)
REGISTRATION FORM 2018-2019

Child's Name ____
(First) (Last)

Mailing Address ____

____
(City) (Zip)

Home Phone ____

Date of Birth ______________ Male/Female Grade ________________

Email Address: ____
(This email is used for billing purposes and Extended Care communication only.)

Father/Guardian's Name ______________________

Address ______________________________

Home Phone ___________ Cell Phone ____________

Place of Employment __________Work Phone ______________

Mother/Guardian's Name ______________________

Address______________________________

Home Phone ___________ Cell Phone ____________

Place of Employment __________Work Phone ______________

PSEC Rates (Payment is required on a bi-weekly basis)

7:00am-6:00pm M-F $4.00/hour

PSEC is open on days that STV Preschool is open.

If your child will be in the PSEC program for lunch (10:45AM-11:05AM or 12:05-12:25PM), you will need to either pack a lunch for your child or pay ahead in the school office for a hot lunch for your child.

A registration fee of $25, required per family, must accompany this registration form.

Please contact the school office for additional information if needed or you may email amayvill@cdeducation.org.

______________________________________ ______________________

Parent/Guardian Signature Date

By signing the below I am stating that I have read the contents of the SACCP/PSEC handbook online on the School Speaks STV website and understand that my child(ren) and I will follow the policies that were set according to the St. Vincent de Paul School SACCP/PSEC Handbook for the 2018-2019 school year.

______________________________________ ______________________

Parent/Guardian Signature Date

DOUBLE SIDED FORM – PLEASE TURN OVER

Student Name (Last, First) ____

In the event this student becomes ill at school but does not need medical attention, name two people, i.e. relative, neighbor, childcare provider, to be contacted if you cannot be reached.
1.________________________ Relationship:______________________ Phone: _________________
2.________________________ Relationship:______________________ Phone: _________________

Please list any other persons that you will allow to pick up your child from Extended Care. Remember they must be on this list to pick up your child. We take this extremely seriously and require a signature upon your child's pick up.
_________________________ Relationship:______________________ Phone: _________________
_________________________ Relationship:______________________ Phone: _________________
_________________________ Relationship:______________________ Phone: _________________
_________________________ Relationship:______________________ Phone: _________________

____ _______________________________
Parent/Guardian Signature Date

Please give any pertinent information regarding the health of this child: ____
____
____

Emergency Medical Authorization (State of Ohio Revised Code Section 3313.712)

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority when parents or guardians can not be reached.

PART I or PART II MUST BE COMPLETED
PART I: TO GRANT CONSENT
I herby give consent for the following medical care providers and local hospital to be called
Physician: __________________________ Phone: ________________________
Dentist: ____________________________ Phone: ________________________
Medical Specialist:_____________________ Phone:_________________________
Local Hospital:________________________ Emergency Room Phone:____________

In the event reasonable attempts to contact me have been unsuccessful, I herby give my consent for (1) the administration or any treatment deemed necessary by above named doctors, or, in the event the designated preferred practitioner is not available by another licensed physician, dentist, and (2) the transfer of the child to any hospital reasonably accessible.
This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists concurring on the necessityfor such surgery are obtained prior to the performance of such surgery.
Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted: ____
____
____
____

Date: __________ Signature: ____________________________________

DO NOT COMPLETE PART II IF YOU COMPLETED PART I
PART II: REFUSAL TO CONSENT
I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish school authorities to take the following action. ____
____
____

Date: __________ Signature: ____________________________________

DOUBLE SIDED FORM – PLEASE TURN OVER