



PRESCHOOL / PRE-K  
St Vincent de Paul School

<b>Print Child's Last Name:</b>
Office Use Only:

**PRESCHOOL EXTENDED CARE PROGRAM**  
**PSEC REGISTRATION FORM 2019-2020**

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 \_\_\_\_\_

Mother/Guardian's Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Place of Employment \_\_\_\_\_ Work 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 [stvecare@cdeducation.org](mailto:stvecare@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 2019-2020 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't be reached.

**PART I or PART II MUST BE COMPLETED**

**PART I: TO GRANT CONSENT**

I hereby 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 hereby 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 necessity for 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: \_\_\_\_\_

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