St. Augustin PK, TK and K-8 Extended Care
4320 Grand Avenue
Des Moines, IA 50312

COMPLETE ONE FORM FOR EACH CHILD

Please list children's food allergies, if any:____

Child(ren)'s Name ________________________ Age_____ Birthdate___________ Grade______ Sex_________

CARE DESIRED: Before Care______________ After Care____________ Before & After Care________________

Mother's Name ____ Home Phone __________________________

Address ____ Cell Phone __________________________

Employer ____ Work Phone __________________________

Email Address____

Father's Name ____ Home Phone __________________________

Address ____ Cell Phone __________________________

Employer ____ Work Phone __________________________

Email Address____

Emergency Information:
In the event that my child may require emergency medical, dental, or surgical care while I am unable to be reached, I hereby give my consent to medical, dental, or surgical treatment to:

Doctor/Clinic Name ______________________ Address_____________________ Phone __________________

Hospital (circle one) – Broadlawns Mercy West Mercy (Downtown) Mercy West Lakes (60th) Lutheran

Methodist (Downtown) Methodist West (60th) Blank Children's Hospital

Dentist Name ____ Phone ______________________________

Dentist Address ____
I agree to pay all the costs and fees contingent on emergency care or treatment for my child as secured or authorized under this consent.

In an emergency please call: (in case parents are unreachable)

Name/Relation: ____________________________________ Phone __________________ Cell ________________

Name/Relation: ____________________________________ Phone __________________ Cell ________________

Pick Up Permission- Please circle yes or no for the following:

Yes / No I hereby give permission for my child to leave the center for fieldtrips in a vehicle provided by the center, or on foot. I give permission for my child to be transported to and from school in the vehicle provided by the center. A childcare employee will transport my child to and from school in a center provided vehicle.

Yes / No I hereby give permission for my child to leave the center with the following persons named below. It is the responsibility of the parent to notify the center, in writing, of any changes.
Name_______________________________________ Relationship_______________________________
Name_______________________________________ Relationship_______________________________

Yes / No I grant center staff the right to take photographs of my child engaged in center activities to be displayed within the center.

Names of persons who may not pick up the child:____
Separation, divorce, or other custody situations the center should be aware of:_________________________
____

______________________________________ ______________
Parent/Guardian Signature Date

Immunization and physical forms available in the school office and electronically.

St. Augustin Before / After Care Program
Emergency Medical Authorization

(Form must be returned by the first day of attending Before/Aftercare.)

I, ____________________________________, mother/father/guardian of ______________________________________, age _____, grade _____,

do hereby give my permission and/or consent to St. Augustin School Before/After Care Program to secure and authorize such emergency medical care and/or treatment as my child named above might require while under the supervision of St. Augustin School Before/After Care Program. I also 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.

NOTE: Every effort will be made to notify parents/guardians IMMEDIATELY in case of emergency. In the event of an emergency, it would be necessary to have the following information.

Name of Physician to contact:________________________________

Physician's Phone #:____

Name of Hospital:____

I agree to this authorization for the period of time that my child attends St. Augustin School Before/After Care Program and will inform the school as to any change in name of physician or hospital.

_______________________________________ _________________________
Signature of Parent/Step-Parent/Guardian Date