



ST. PIUS X CATHOLIC SCHOOL
 2017-2018 EXTENDED DAY PROGRAM
 52553 Fir Road – Granger, IN 46530
 Phone: (574) 272-8462

Program Director
 Jessica Willamowski (jwillamowski@stpius.net)

Program Administrator
 Elaine Holmes-Principal

Parent(s)/Guardian Information

 Name Relationship to child Home Phone Cell Phone Email Address

 Employer Work Phone Child resides with this person? (Circle) Yes No

 Name Relationship to child Home Phone Cell Phone Email Address

 Employer Work Phone Child resides with this person? (Circle) Yes No

Parent's Marital Status Married ____ Divorced ____ Separated ____ Widowed ____ Single ____

Any custody situation we should be aware of? _____

Emergency Contacts In the event of an emergency, please contact:

1) _____
 Name Relationship to child Phone

2) _____
 Name Relationship to child Phone

After School Pick Up Authorization List the names of the people who may pick up your child.

 Name Name

 Name Name

List the names of the people who **MAY NOT** pick up your child.

 Name Name

 Name Name

Signature: _____ Date: _____



ST. PIUS X CATHOLIC SCHOOL
 2017-2018 EXTENDED DAY PROGRAM
 52553 Fir Road – Granger, IN 46530
 Phone: (574) 272-8462

Program Director
 Jessica Willamowski (jwillamowski@stpius.net)

Program Administrator
 Elaine Holmes-Principal

MEDICAL FORM

In the event that any of my children listed below may require medical and/or surgical care while I am out of the city or unable to be reached, I hereby give my consent to medical and/or surgical treatment to _____ hospital and to doctor _____ or his/her designee to provide this care. I agree to pay all the costs and fees contingent on any emergency medical care and/or treatment for my child as secured or authorized under this consent. Note: We will make every effort to notify parents/guardians immediately in case of emergency.

This consent will be in effect beginning August 16, 2017 and continuing while the child is enrolled in the Extended Day Program.

_____ Child's Full Name _____ Birth Date

Allergies (food, medication, bees): _____

Medication: _____

_____ Child's Full Name _____ Birth Date

Allergies (food, medication, bees): _____

Medication: _____

_____ Child's Full Name _____ Birth Date

Allergies (food, medication, bees): _____

Medication: _____

_____ Child's Full Name _____ Birth Date

Allergies (food, medication, bees): _____

Medication: _____

_____ Child's Full Name _____ Birth Date

Allergies (food, medication, bees): _____

Medication: _____

Signature: _____ Date: _____