Immaculate Conception School
Extended Care Registration
452 Bow Street
Elkton, MD 21921
410-398-2636

$15 registration fee and this form are due no later than September 3, 2009.
$15 late fee will apply after due date.

Name of student: ____**Birth date:** ___________

Name of parents: ____

Address: ____

Telephone number: ________________**Approximate pick up time of student:** __________

Place of employment: (mother) ____

(father) ____

Work phone number: (mother) _______________________ **(father)** _________________

Cell phone number: (mother) _______________________ **(father)** _________________

PERSON OTHER THAN PARENT TO BE NOTIFIED IN AN EMERGENCY SITUATION WHEN PARENT IS NOT AVAILABLE:

Name:_______________________________________**Relation to child:** ________________

Address: ____________________________________ **Telephone number:** ____________

NAME OF PERSONS OTHER THAN PARENTS TO WHOM CHILD CAN BE RELEASED:

(1)____________________________________ **(2)** __________________________________

EMERGENCY MEDICAL CARE

I, ____, **the parent (or legal guardian) of**

____, **who is my minor child, hereby authorize emergency medical treatment for my child in the event that I cannot be contacted. I give permission to treat my child. I understand that I will be financially responsible for the cost of such treatment.** _____________________________________

Parent Signature

Name of child's physician: ____

Physician's telephone number: ___________________**Office hours:** ________________

Special medical information (allergies, etc.): _____________________________________