



LAWRENCE CATHOLIC ACADEMY

Extended Day Program Application

(978) 683-5803

Family Information

Family Name: _____

Family Home Phone Number: () _____ - _____

Family Email Address: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Parent/Guardian Information

Name: _____

Relationship: _____

Home Address: _____

Phone Number: () _____ - _____
Reachable during program hours

Employer: _____

Occupation: _____

Employer City: _____

Work Phone Number: () _____ - _____

Work Hours: _____

Parent/Guardian Information

Name: _____

Relationship: _____

Home Address: _____

Phone Number: () _____ - _____
Reachable during program hours

Employer: _____

Occupation: _____

Employer City: _____

Work Phone Number: () _____ - _____

Work Hours: _____

Emergency Contacts (EC) and Alternative Pick-up Person (APP): You are required to list at least two people with whom you feel comfortable leaving your child and who can assume responsibility for your child if you could not be reached immediately in an emergency, or if for some reason you could not pick up your child and were unable to communicate with the program. Any changes to this list must be done in writing. No exceptions! Please understand that we will ask for identification from anyone unfamiliar to us.

***If a child is protected by a restraining order please submit a copy.**

#1 Contact Name: _____

Relationship: _____

Address: _____

Phone Number(s): _____ or _____

EC: _____ APP: _____

#3 Contact Name: _____

Relationship: _____

Address: _____

Phone Number(s): _____ or _____

EC: _____ APP: _____

#2 Contact Name: _____

Relationship: _____

Address: _____

Phone Number(s): _____ or _____

EC: _____ APP: _____

#4 Contact Name: _____

Relationship: _____

Address: _____

Phone Number(s): _____ or _____

EC: _____ APP: _____

Extended Day Program Application (cont.)

Child #1 Name: _____

Grade/Homeroom: _____ Age: _____ Sex: _____

Date of Birth: ___/___/___

List any chronic conditions, dietary restrictions, or medications:

List any allergies, reactions, and treatment:

Child #2 Name: _____

Grade/Homeroom: _____ Age: _____ Sex: _____

Date of Birth: ___/___/___

List any chronic conditions, dietary restrictions, or medications:

List any allergies, reactions, and treatment:

Child #3 Name: _____

Grade/Homeroom: _____ Age: _____ Sex: _____

Date of Birth: ___/___/___

List any chronic conditions, dietary restrictions, or medications:

List any allergies, reactions, and treatment:

Child #4 Name: _____

Grade/Homeroom: _____ Age: _____ Sex: _____

Date of Birth: ___/___/___

List any chronic conditions, dietary restrictions, or medications:

List any allergies, reactions, and treatment:

Physician: _____ Phone Number: () _____ - _____

Physician Address: _____

Child(ren)'s Dentist: _____ Phone Number: () _____ - _____

Insurance Carrier: _____ Policy #: _____

Do you have a custody agreement, court order, and/or restraining order pertaining to your child(ren)? If yes, please attach: _____

Circle Days Needed

Morning Program	Mon.	Tues.	Wed.	Thurs.	Fri.
Afternoon Program	Mon.	Tues.	Wed.	Thurs.	Fri.

Transportation Plan

MY CHILD WILL ARRIVE TO THE PROGRAM BY:

_____ Parent Drop Off

_____ Contract Bus

_____ Private Trans. Arranged by Parent

MY CHILD WILL DEPART FROM THE PROGRAM BY:

_____ Parent Pick Off

_____ Contract Bus

_____ Private Trans. Arranged by Parent

Extended Day Program Application: There is a \$15.00 registration fee per family. Please return this form with your payment. Please make checks payable to Lawrence Catholic Academy. The After School Program is \$5.00 for the first hour and \$15.00 for the day.

Extended Day Program Application (cont.)

Emergency Medical Authorization

I hereby give _____ permission to administer basic first aid
(Name of provider)

and/or CPR to my child/children _____, to a
(Name of child/children)

hospital for medical treatment when I cannot be reached or when a delay may be dangerous to my child's health.

Parent/Guardian Signature: _____ Date: _____