

**ST. VINCENT DE PAUL CATHOLIC SCHOOLS**  
**Junior High After School Program Registration Form**

Name of Child(ren): 1) \_\_\_\_\_  
2) \_\_\_\_\_

Please mark the days your student will be attending the After School Program:

Monday \_\_\_ Tuesday \_\_\_ Wednesday \_\_\_ Thursday \_\_\_ Friday \_\_\_

\*\*\*If possible, parents should notify ASP coordinators at least one week in advance of a schedule change\*\*\*

Mother's Full Name: \_\_\_\_\_ Father's Full Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Phone#: \_\_\_\_\_

Email Address: \_\_\_\_\_ Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

**PEOPLE WHO HAVE PERMISSION TO PICK UP MY CHILD.** If the person is not listed below, please send a signed note to the office or the person will not be able to pick up your child. Parents listed above will always be able to pick up their children unless ASP is otherwise notified.

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

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Please note any allergies, medical concerns or medications taken. If none, write N/A.

Child 1 Name: \_\_\_\_\_ Note: \_\_\_\_\_

Child 2 Name: \_\_\_\_\_ Note: \_\_\_\_\_

My signature below indicates that I have read the information for the St. Vincent After School Program and agree to follow all guidelines. I authorize ASP personnel to use the above information in the care/safety of my child(ren).

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_