OUR LADY OF SORROWS
AFTER SCHOOL PROGRAM REGISTRATION
2018-2019

DATE: _____

Please Print or Type All Information

CHILD/CHILDREN'S FULL NAME **GRADE**

_____ _____

_____ _____

_____ _____

_____ _____

PARENT'S/GUARDIAN'S FULL NAME AND ADDRESS **HOME PHONE NO.**

_____ _____

_____ _____
Mother's cell phone number

_____ _____
Father's cell phone number

MOTHER'S WORK NUMBER _____ **FATHER'S WORK NUMBER** _____

PEOPLE TO CONTACT IN CASE OF EMERGENCY **PHONE NUMBER**
Please list 2 emergency contacts

_____ _____

_____ _____

DO ANY OF YOUR REGISTERED CHILDREN HAVE ANY CHRONIC HEALTH PROBLEMS? _____
IF YES, PLEASE SPECIFY THE NATURE OF THE PROBLEM:

DO ANY OF YOUR REGISTERED CHILDREN HAVE ALLERGIES TO FOODS OR MEDICINES? _____
IF YES, PLEASE SPECIFY THE ALLERGY:

DO ANY OF YOUR REGISTERED CHILDREN TAKE MEDICATION ON A REGULAR BASIS? _____
IF YES, PLEASE SPECIFY THE MEDICINE AND REASON IT IS TAKEN:

IN CASE OF A LIFE THREATENING EMERGENCY, WHEN IMMEDIATE ACTION IS NECESSARY TO SAFEGUARD THE HEALTH AND WELL BEING OF MY CHILD/CHILDREN, I AUTHORIZE THE STAFF OF OUR LADY OF SORROWS AFTER SCHOOL PROGRAM TO TAKE THE NECESSARY MEASURES. I UNDERSTAND THIS TO MEAN TRANSPORTATION TO AND TREATMENT BY A HOSPITAL IF A LIFE THREATENING SITUATION HAS OCCURRED.

BY SIGNING THIS FORM, YOU INDICATE TO ABIDE BY ALL PROCEDURES, ETC. REGARDING ASP.

_____ _____
PARENT/S/GUARDIAN/S SIGNATURE **DATE**

PLEASE MAKE CHECK PAYABLE TO O.L.S.A.S.P. AND RETURN WITH THIS FORM TO O.L.S.

REGISTRATION FEE…….$35.00 PER FAMILY