



St. Catherine
Early Childhood Education Center
Registration Form
2022-2023



| | |
|--------------------------------------|---------------|
| Child's Name | Date of Birth |
| Address | Home phone |
| City State | Zip code |
| Catholic Yes No Parish Name _____ | Ethnicity |

| | |
|----------------------|--------------|
| Parent/Guardian Name | Relationship |
| Address | Home phone |
| City State Zip Code | Cell phone |
| Email | Work phone |

| | |
|----------------------|--------------|
| Parent/Guardian Name | Relationship |
| Address | Home phone |
| City State Zip Code | Cell phone |
| Email | Work phone |

Please list two people to be contacted in the event of an emergency if the parent cannot be contacted:

| | |
|-----------------------|-----------------------|
| Name | Name |
| Address | Address |
| City | City |
| State Zip Code | State Zip Code |
| Relationship to child | Relationship to child |
| Home Phone | Home Phone |
| Cell Phone | Cell Phone |
| Work Phone | Work Phone |

Annual class roster

Each year we prepare a roster for each group of children in our program. The roster includes parent(s) & child's name as well as phone number. This roster will not be furnished to any persons other than parents of children enrolled in our program.

I authorize my child's name, parent(s) name and phone number to be listed on the roster. Yes No

Signature of parent or guardian

| |
|----------------------------|
| Chronic Physical Problems* |
| Allergies* |
| Medications, Supplements* |

*If any of these require symptoms to be watched for and/or medications to be given at school another form must be completed.

Do any of the above require that symptoms are watched for and medication given while at school if needed? Yes No

List of Person(s) to whom this child can be released in addition to those listed on the front: (please print)

| |
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| |
| |

List of Persons NOT PERMITTED to pick up this child: (please print)

| | |
|--|---|
| | Restraint Papers or Divorce decree attached |
| | YES NO |

| | |
|------------------|------------------|
| Physician Name | Dentist Name |
| Street Address | Street Address |
| City, State, Zip | City, State, Zip |
| Phone | Phone |

_____ or any hospital reasonably accessible
Emergency Hospital

Check One

In the event that reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of treatment deemed necessary by above named doctors or (2) the transfer of the child to the above designated hospital or any hospital reasonably accessible.

I do not give my consent for emergency medical treatment of my child. In the event of an illness or injury requiring emergency treatment, I wish the school authorities to take the following action.

X _____ Date _____
Signature