St. Catherine
Early Childhood Education Center
Registration Form

ckummer@stcatherineearlyed.org FAX 419-478-9434

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)

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