

**ST. STEPHEN MARTYR PRE-SCHOOL**  
**And Out of School Care**  
**Registration, Information and Financial Agreement**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Who Does Child Live with? \_\_\_\_\_

Name of Father/Male Guardian: \_\_\_\_\_

Name of Mother/Female Guardian: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Mom Cell #: \_\_\_\_\_

Dad Cell #: \_\_\_\_\_ Other: \_\_\_\_\_

Who should we contact first if needed? \_\_\_\_\_

Are you Catholic \_\_\_\_\_? If yes, with what parish are you a member? \_\_\_\_\_

**E-Mail address** \_\_\_\_\_

**Approved Parties to Pick Up Child:** (Only those listed will be able to pick up child)

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

**Emergency Contact Information:**

Father's Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Mother's Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Emergency Contact #1

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact #2

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Child's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Insurance Info:

Carrier Name \_\_\_\_\_ Group: \_\_\_\_\_ I.D. \_\_\_\_\_

Who carries the Insurance? \_\_\_\_\_

(Please Provide us with a photocopy of your Medical Insurance Card, Front and Back)

**ST. STEPHEN MARTYR PRE-SCHOOL**  
**And Out of School Program**  
**Registration, Information and Financial Agreement**

Child's Name: \_\_\_\_\_

**Medical Information:**

Does your child have an updated immunization card? \_\_\_\_\_

*All children entering the pre-school program are required to have Physicals and Current Immunization shots and eye exam before school starts in August. Please return this form to us by the beginning of the school year.*

Does your child have any allergies? (Please List clearly) \_\_\_\_\_

Does your child have any physical limitations that would interfere with regular Pre-School Activities? (Please describe clearly) \_\_\_\_\_

Please indicate with **YES** or **NO** to the following questions:

Has your child ever had: Chicken Pox? \_\_\_\_\_ Mumps? \_\_\_\_\_  
Whooping Cough? \_\_\_\_\_ Polio? \_\_\_\_\_ Scarlet Fever? \_\_\_\_\_

Other? \_\_\_\_\_

Is your child on any medication? (Please List Clearly)

Medication #1 \_\_\_\_\_ For What Treatment \_\_\_\_\_

Medication #2 \_\_\_\_\_ For What Treatment \_\_\_\_\_

Medication #3 \_\_\_\_\_ For What Treatment \_\_\_\_\_

*(Parents must complete a Prescription Authorization Form in order for the Daycare to administer any Medications. See Director for Form or print it from the [ssmartyr.org](http://ssmartyr.org) website)*

**Medical Consent**

In case of an Emergency and I/We cannot be reached, I/We hereby authorize the St. Stephen Martyr Pre-School & out of School Program Director/Care Giver to obtain emergency Medical Care of my Child \_\_\_\_\_.

*(Child's Name)*

**Signature of Parent (Guardian)** \_\_\_\_\_ **Date:** \_\_\_\_\_

Signature of Parent (Guardian) \_\_\_\_\_ Date: \_\_\_\_\_

**Signature of Parent (Guardian)** \_\_\_\_\_ **Date:** \_\_\_\_\_

Hospital of Choice: \_\_\_\_\_ Telephone: \_\_\_\_\_

**ST. STEPHEN MARTYR PRE-SCHOOL  
And Out of School Program  
Registration, Information and Financial Agreement**

Child's Name: \_\_\_\_\_

**Financial Agreement**

I, as a Parent/Guardian of the above named child, do hereby agree to pay the scheduled amount of charges as stated. I understand that my payment is due by the 10th of the Month if paying monthly preschool charges only, and due prior to services weekly for all other services. I understand that I am responsible for any late fees and any returned check fees. I understand that my registration fee is non-refundable unless I am not accepted into the program. I understand that upon registering for summer care that I am responsible for payment for the entire St. Stephen Martyr summer break with the exception of the Friday of our parish picnic and two weeks (10 days ) vacation if I decide to use them.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

**Enrollment Status**

*Please Check One:*

Pre-School Only     Pre-School and Daycare     Pre-School and  
Part-time Daycare  
 After School Care Full-time     After School Care Part-time

**Days Daycare is Needed**

*Please check all days needed:*

Monday     Tuesday     Wednesday     Thursday     Friday

**Payment Frequency**

*Please Check One:*

Weekly     Monthly (Available for Pre-School Only Status)