

INFANT JESUS SCHOOL
Before/After School Program
3 Crown St., Nashua, NH 03060
889-2649/883-8978 after 3:30 p.m.

REGISTRATION FEE \$16.50 PER FAMILY TO ACCOMPANY THIS FORM

REGISTRATION INFORMATION:

PARENTS/GUARDIANS: _____

ADDRESS: _____ PHONE: _____

CITY: _____ STATE: _____ ZIP: _____

FATHER'S CELL PHONE: _____ MOTHER'S CELL PHONE: _____

FATHER'S EMPLOYER: _____ PHONE: _____

MOTHER'S EMPLOYER: _____ PHONE: _____

NAME(S) OF CHILDREN NEEDING PROGRAM:

HOMEROOM

PLEASE LIST ALL PERSONS ALLOWED TO PICK UP YOUR CHILD(REN)
(You must include Parents/Guardians names if they will be picking up)

	RELATIONSHIP: MOTHER
	RELATIONSHIP: FATHER
	PHONE _____ RELATIONSHIP _____
	PHONE _____ RELATIONSHIP _____

PERSON RESPONSIBLE FOR PAYMENT, IF DIFFERENT THAN PARENTS/GUARDIANS

NAME & ADDRESS _____

NOTE: special arrangements for individual/emergency needs will be made after personal dialogue with the Principal. Circumstances that warrant legal arrangements must be made known to the School, along with documents.

IF PARENTS/GUARDIANS CANNOT BE REACHED, WHO SHOULD BE CALLED IN CASE OF AN EMERGENCY?

1. NAME: _____ HOME PHONE: _____

RELATIONSHIP: _____ CELL PHONE: _____

2. NAME: _____ HOME PHONE: _____

RELATIONSHIP: _____ CELL PHONE: _____

WHICH DOCTOR, HOSPITAL OR URGENT CARE CLINIC SHOULD BE CALLED IN AN EMERGENCY?

1ST CHOICE: _____ PHONE: _____

2ND CHOICE: _____ PHONE: _____

HOSPITAL _____

PLEASE LIST ANY:

ALLERGIES: _____

OTHER CONDITIONS: _____

(The final decision for action will be the judgment of school authorities. If any of the above is changed, please contact the Principal in writing as soon as possible. Thank You!)

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

BY SIGNING THIS FORM YOU GIVE YOUR PERMISSION FOR EMERGENCY MEDICAL TREATMENT OF YOUR SON/DAUGHTER.