CLUB *SOAR* REGISTRATION FORM

Please choose which session(s) you are Registering for below.

☐ **Morning Session**
6:40 am to 8:00 am
$5 a Day

Please select the days of the week that your child(ren) will attend the above session.

☐ **Monday** ☐ **Tuesday** ☐ **Wednesday** ☐ **Thursday** ☐ **Friday**

☐ **After School Early Session**
3:15pm to 4:30pm
$5 a Day

☐ **After School Late Session**
3:15pm to 5:30pm
$10 a Day

Please select the days of the week that your child(ren) will attend the above session.

☐ **Monday** ☐ **Tuesday** ☐ **Wednesday** ☐ **Thursday** ☐ **Friday**

A non-refundable registration fee of **$50.00** is due at registration.
Unless an exception is made by the business office, re-enrollment in a subsequent semester will be denied if payments are not current.

Child's Name _____ Nickname Used _____
Last First M.I.
Age _____ Grade: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

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Child's Name _____ Nickname Used _____
Last First M.I.
Age _____ Grade: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

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Child's Name _____ Nickname Used _____
Last First M.I.
Age _____ Grade: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

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Parent/Guardian Home Address and Employment Information:

Child Lives With (circle one): Both Parents Mother Father Guardian

Father (or Guardian)
Name: _____
Address: _____
City: _____ State _____ Zip _____
Home Phone: _____
Cell Phone: _____
Employer: _____
Work Phone: _____ EXT _____
Email Address: _____

Mother (or Guardian)
Name: _____
Address: _____
City: _____ State _____ Zip _____
Home Phone: _____
Cell Phone: _____
Employer: _____
Work Phone: _____ EXT _____
Email Address: _____
*****(Please fill out Reverse side of form)*****

Person(s) to whom the child(ren) may be released by the caregiver and emergency contact when a parent cannot be reached.

Name: _____
Relationship: _____
Address: _____
City: _____ State _____ Zip _____
Home Phone: _____
Cell Phone: _____

Name: _____
Relationship: _____
Address: _____
City: _____ State _____ Zip _____
Home Phone: _____
Cell Phone: _____

Consent to contact physician in Emergency:
In the event I cannot be reached to make arrangements, I hereby give my consent to Holy Cross to contact:
Name of Physician: _____Phone:_____
and, if necessary, take my child to the following clinic or hospital:_____
_____

Company providing health and/or accident insurance coverage:_____

Child's Medical Information:
Any health problems which caregiver should know regarding any of the children: _____
_____

Medication, if any: _____
Physical Limitations:_____
Any activities child should NOT engage in:_____

Extended care bills are sent out the 1st week of each month and are due by the 15th. A late payment fee of $20 will automatically be charged to your account if payment is not received by the 15th. Thanksgiving break, Christmas break, and Easter break are not billed. All other weeks will be charged at the weekly fee. We cannot charge for partial weeks due to staffing and placement.

Extended Care Handbook Acknowledgment :
We have read and understand all the provisions set forth in the Holy Cross Extended Care Program Handbook. We pledge our cooperative support of these policies.

_____
Signature of Parent (Guardian) *Date*

(For Office Use Only)
DATE REGISTERED:

$50.00 Non-Refundable Registration Fee Received **Cash** **Check#**

Notes: