2018-2019

St. Thomas Aquinas Regional School
Extended Day Registration

$20 family registration fee required
Check #_____
Cash _____
Credit_____
FACTS_____
PAID

I. Student Information

Name	Phone	Grade
Address	parent email	D.O.B.
Start Date:	Withdrawal Date:	
Allergies/Conditions:		

II. Parent/Guardian Information

Mother	Father
Name	Name
Address (if Different)	Address (if Different)
Cell Phone	Cell Phone
Place of Employment	Place of Employment
Work Phone	Work Phone

III. Sessions (circle all needed)

Mornings	*Afternoons*	*Early Release*
A1 6-8 am	B1 3-4pm	ER1 12noon-3pm
A2 7-8 am	B2 3-5pm	ER2 2-3pm
	B3 3-6pm	

IV. Pick Up Authorizations

Persons **Authorized** to pick up child:
Persons **Not Authorized** to pick up: (Documentation Required)

V. Billing / Payment Options (please check)

Billing Method		Payment Method	
	Paper invoice		Charge to FACTS
	Email Invoice: Email to:		Check/Cash/Credit Card

VI. Parent Authorization

Signature: **Date:**

STARS Extended Day Medication Policy
ACKNOWLEDGEMENT

This form must be signed in order to consider registration complete! *This form does NOT indicate that medication will to be administered to your child. It serves only to inform you of our policy to administer medication if the need should arise and* ***IF*** *you request it.*

Acknowledgement of Medication Administration Policy

The Aquinas Extended Day Program will administer* prescription and non- prescription medications to students when administration of medications is **requested by and ONLY when requested by the parent/guardian**. Such medications must be provided by the parent along with the appropriate documents (found on the forms page of the school website). Please sign below acknowledging that you have been informed of this policy via the above statement.

Signature below is required *for each student enrolled in the program, whether or not medication is administered.*

Provider and the parent of each enrolled child must sign below. The provider must maintain a copy of this form in each child's individual record.

Provider's Name (please print): Julianna McNulty	Facility Name: Aquinas School Day Program
Provider's Signature:	Date:
Parent's Signature:	Date:

* All qualified staff are Mat trained and follow all requirements and confidentiality conditions as required and stated in the STARS Parent Handbook.

Office Use Only

The above named student currently enrolled at STARS has a copy of his/her :

1.health/shot record on file in the nurse office

2.Birth record on file in the School office

Verified by:_____

EXTENDED DAY EMERGENCY CONTACT FORM

1 Form per Family

STUDENT NAME(S):

_____

_____

_____

PARENT/GUARDIAN NAME	PARENT/GUARDIAN NAME
CELL	CELL
WORK	WORK
HOME	HOME

To be completed in **full** for Extended Day program purposes. Emergency contacts must be 2 persons **OTHER** than the Parents/legal guardian who can be contacted when staff are unable to contact either parent/guardian in an emergency.

EMERGENCY CONTACT 1:	
Name	
Address:	
State:	ZIP:
PHONE:	
PHONE:	
Relationship to Student:	

EMERGENCY CONTACT 2:	
Name	
Address:	
State:	ZIP:
PHONE:	
PHONE:	
Relationship to Student:	