

**TRUE CROSS CATHOLIC SCHOOL  
EXTENDED DAY REGISTRATION FORM**

**THIS FORM MUST BE FILLED OUT BY ALL FAMILIES**

1. Child's name \_\_\_\_\_ Grade \_\_\_\_\_ Birthday \_\_\_\_\_

2. Child's name \_\_\_\_\_ Grade \_\_\_\_\_ Birthday \_\_\_\_\_

3. Child's name \_\_\_\_\_ Grade \_\_\_\_\_ Birthday \_\_\_\_\_

Mother's name \_\_\_\_\_

Address \_\_\_\_\_

Street

City

State

Zip

Phone \_\_\_\_\_ (home) Business phone \_\_\_\_\_

Area code & number

Area code & number

Cell Phone \_\_\_\_\_

Area code & number

Father's name \_\_\_\_\_

Address \_\_\_\_\_

Street

City

State

Zip

Phone \_\_\_\_\_ (home) Business phone \_\_\_\_\_

Area code & number

Area code & number

Cell Phone \_\_\_\_\_

Area code & number

Parents status: Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_

Emergency Information:

Persons authorized to pick up child(ren) enrolled other than parents:

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Please list any allergies, disabilities, restrictions or special needs that your child may have:

Child's Doctor \_\_\_\_\_ Office Phone \_\_\_\_\_

Hospital Preference \_\_\_\_\_

I agree that the staff may authorize a physician to provide emergency care in the event that I cannot be contacted immediately.

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