

# AFTER SCHOOL CARE REGISTRATION

CATHOLIC ACADEMY OF PASSAIC COUNTY

Saint Gerard Majella  
SCHOOL

Grade Entering in Sept. \_\_\_\_\_

PAID \_\_\_\_\_

AFTER SCHOOL CARE REGISTRATION FOR THE SCHOOL YEAR 2016-2017 DATE \_\_\_\_\_

RECEIPT NO \_\_\_\_\_

CHILD

\_\_\_\_\_  
FAMILY NAME

\_\_\_\_\_  
CHILD'S LAST NAME

\_\_\_\_\_  
FIRST NAME

Indicate two(2) EMERGENCY Resources to call should your child become ill

EMERGENCY PHONE NUMBER: \_\_\_\_\_

EMERGENCY PHONE NUMBER: \_\_\_\_\_

NAME OF PERSON TO CONTACT  
FOR EMERGENCY: \_\_\_\_\_

NAME OF PERSON TO CONTACT  
FOR EMERGENCY: \_\_\_\_\_

RELATION TO STUDENT: \_\_\_\_\_

RELATION TO STUDENT: \_\_\_\_\_

FAMILY

MAILING ADDRESS:

MR. AND MRS. \_\_\_\_\_

STREET: \_\_\_\_\_

CITY \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME TELEPHONE: \_\_\_\_\_

REGISTRATION FEE IS NON-REFUNDABLE