



# St. Clement of Rome School

## AFTER SCHOOL CARE 2017-2018

**Time:** 3:05 – 6:00 p.m.

**Before/After care Registration Fee:** \$15.00 per child - due with application.

<b>Rates:</b>	Student(s)	First Hour	Each Additional Hour	Monthly
	1	\$5.00	\$4.00	\$150
	2	\$7.00	\$6.00	\$230
	3	\$9.00	\$8.00	\$300

**Hourly rates:** Payments are due on Friday. No partial hour payments are allowed.

\*August is a lagniappe month to make up for holidays.

\* \* \* \* \*

### After School Care Registration Form

Student: \_\_\_\_\_  
Last Name
First Name
Grade

Student: \_\_\_\_\_  
Last Name
First Name
Grade

Student: \_\_\_\_\_  
Last Name
First Name
Grade

Parents/Guardians: \_\_\_\_\_  
Name(s)

Address: \_\_\_\_\_  
City & ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_  
Primary Email: \_\_\_\_\_

Mother's Cell #: \_\_\_\_\_

Father's Cell#: \_\_\_\_\_

Mother's work #: \_\_\_\_\_

Father's work #: \_\_\_\_\_

**(OVER)**

In case of emergency and I am unable to be reached, please contact: (please provide at least two names)

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

Office Phone: \_\_\_\_\_

Hospital: \_\_\_\_\_

In the event of an emergency, St. Clement of Rome will use the services of East Jefferson Hospital unless otherwise instructed.

My child \_\_\_\_\_ **may** have a snack.

\_\_\_\_\_ **may not** have a snack.

Please list any pertinent information regarding your child/children.

Students are expected to behave appropriately. Consistent misbehavior will not be tolerated.

Parents will be notified and asked to find an alternative program.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**This form is due on or before May 15, 2017.**

**Make checks payable to St. Clement of Rome School.**