St. John's Lutheran School, Lombard

Before Care/After Care Program Guidelines/Regulations

2023-2024

Last Name _____ Address _____ City _____

Child(ren)'s First Name(s) & Grade(s) _____

Mother's Name _____ Home Phone # _____

Work Phone # _____ Cell Phone # _____

Email _____

Father's Name _____ Home Phone # _____

Work Phone # _____ Cell Phone # _____

Email _____

Please list the people that are allowed to PICK-UP your child.
Indicate if this person is an **EMERGENCY** contact.

Name _____ Relationship _____

Home Phone # _____ Cell Phone # _____ EMERGENCY CONTACT? YES NO

Name _____ Relationship _____

Home Phone # _____ Cell Phone # _____ EMERGENCY CONTACT? YES NO

Name _____ Relationship _____

Home Phone # _____ Cell Phone # _____ EMERGENCY CONTACT? YES NO

Name _____ Relationship _____

Home Phone # _____ Cell Phone # _____ EMERGENCY CONTACT? YES NO

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If, in the judgment of St. John's School personnel, immediate medical attention is indicated, do you authorize school or extended care personnel to send your child to the hospital? Please circle one

YES **NO**

Known Allergies _____

_____

Medical conditions we should be aware of regarding your child. (please list medications taken daily).

_____

_____

Does your child have asthma? **YES** **NO**

Does your child have an inhaler at school? **YES** **NO**

Does your child have an inhaler in their backpack? **YES** **NO**

Is there any circumstance (custody or otherwise) that we should be aware of regarding your child? Use the space below to describe. This will be kept confidential.

_____

_____

_____

_____

I have read the policy for Before and After Care and payment requirements and understand that failure to pay in a timely manner may cause me to be excluded from the program.

X_____

Parent/Guardian Signature

Please include your deposit of $25.00 per child with this completed form. All payments should be made payable to St. John's Lutheran School.

PLEASE---
SEND YOUR CHILD WITH A SNACK. WE DO NOT PROVIDE SNACKS OR DRINKS (except water)

Office Use Only

BEFORE CARE ☐ AFTER CARE ☐

Date Received_____ Amount Received_____ Check#_____