



# AFTER SCHOOL CARE PROGRAM INFORMATION & REGISTRATION FORM FOR 2024-25

St. Joseph Marquette Catholic School's After School Program provides supervision for students from 3:00 to 6:00 p.m.

The Afterschool Care Program will provide a healthy snack.

Students will be expected to follow all school policies and procedures while in this program.

The program will be available on early dismissal days. **Students need to bring a lunch on early dismissal days.**

**Fees are subject to change for 2024/25**

**FEE PER CHILD:**

3:00 to 4:00 p.m. = \$6.50

3:00 to 5:00 p.m. = \$13.00

3:00 to 6:00 p.m. = \$19.50

**Persons Permitted to Pick Up Your Child(ren)**

Name	Contact Number
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**THERE WILL BE AN ADDITIONAL CHARGE OF \$1.00 PER MINUTE AFTER 6:05 P.M.**

Billing for this program will be handled through the school and will show on your tuition statement. Payment will be due on the 10<sup>th</sup> of each month with the first billing due October 2024. Last billing will be due in July 2025.

Student(s)Name \_\_\_\_\_

List Any Health Problems \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Father's Name: \_\_\_\_\_ Work #: \_\_\_\_\_

Cell #: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Work #: \_\_\_\_\_

Cell #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Home #: \_\_\_\_\_

Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

**If I cannot be reached, I give my permission in a medical emergency, including emergency surgery, for treatment by the doctor named below, or the emergency room at \_\_\_\_\_ hospital.**

Dr. \_\_\_\_\_ Phone #: \_\_\_\_\_

I have read and fully understand the information and will adhere to my fiscal and parental responsibilities. By entering your name, you agree to your fiscal and parental responsibilities.	
Parent Name: _____	Date: _____