EXTENDED CARE ENRICHMENT PROGRAM (ECEP)
REGISTRATION FORM

Student Name #1: ____ GRADE: ______________________

Parent/Guardian: ____

Home phone #: ____

Cell phone #: ____

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Student Name #2: ____ GRADE: ______________________

Parent/Guardian: ____

Home phone #: ____

Cell phone #: ____

Monthly ECEP Fee Payment:

Number of Enrollment Days:	Before School ECEP: Breakfast provided.	After School ECEP: Snacks provided.	Both Before and After School Extended Care Enrichment Program
Full-Time - 4-5 days	$75	$150	$200
Part Time – 2-3 days	$60	$120	$150
Friday only	$45	$75	$100

Number of days: _________________

Monthly fee: $_____________________________

PAID   Date________________________

Received by: _______________________
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EMERGENCY INFORMATION:

Person(s) other than parent who will be picking up student:

Name **Relationship to student** **Phone number**

_____

_____

First person to be notified in case of emergency:

Name: _____

Relationship to student: _____

Home phone #: _____

Cell phone #: _____

Medical Information:

Please list all allergies: _____

_____

Any student with an Epi-pen must have one sent specifically to the extended day program in addition to the one for the classroom. This Epi-pen will be kept and used by extended day personnel specifically.

Any other medical conditions: _____

_____

Other important information regarding your child: _____

_____

The hospital emergency room of my choice is _____

_____

Insurance Carrier: _____ Policy # _____

Credit Cards, Cash and Money Orders payable to: **Mater Dei Catholic**

Memo: **Mater Dei Juan Diego Academy**

1569 Magdalena Avenue **|** p. 619- ____-____ **|** fax. 619-621-5716 **|** www.mdjda.org