



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: \_\_\_\_\_

EMERGENCY INFORMATION:

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

| Name | Relationship to student | Phone number |
|------|-------------------------|--------------|
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**First person to be notified in case of emergency:**

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

Relationship to student: \_\_\_\_\_

Home phone #: \_\_\_\_\_

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

**Medical Information:**

Please list all allergies: \_\_\_\_\_

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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: \_\_\_\_\_

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Other important information regarding your child: \_\_\_\_\_

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The hospital emergency room of my choice is \_\_\_\_\_

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Insurance Carrier: \_\_\_\_\_ Policy # \_\_\_\_\_

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

Memo: **Mater Dei Juan Diego Academy**

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