ST JOSEPH SCHOOL
FAITH AND FAMILY FIRST

AFTER CARE DISMISSAL FORM

Student's Name: _____ _____
Last First

Parent/Guardian Information

Mother's Name: _____ Cell Phone #_____

Father's Name: _____ Cell Phone #_____

The following people are authorized to pick up my child in the event that myself and the aforementioned individual will not be picking up and/or cannot be reached.

Signature:_____ Date: _____

Name: _____ Relationship:_____ Phone #_____

Name: _____ Relationship:_____ Phone #_____

Name: _____ Relationship:_____ Phone #_____

Name: _____ Relationship:_____ Phone #_____

Name: _____ Relationship:_____ Phone #_____

**Please note that only the individuals listed above will be allowed to pick up your child. All individuals will be required to present a valid ID before your child is released to them. Please notify Mrs. Jensen in writing of any changes or additions to this list.*

In case of illness or accident please contact:

Name: _____

Phone #: _____

Hospital: _____

Ins. Provider: _____