ST JOSEPH SCHOOL
FAITH AND FAMILY FIRST

AFTER CARE REGISTRATION FORM

Family Name_____

Child's Name_____**D.O.B.**_____**Grade**:_____

Child's Name_____**D.O.B.**_____**Grade**:_____

Child's Name_____**D.O.B.**_____**Grade**:_____

Child's Name_____**D.O.B.**_____**Grade**:_____

Parent/Guardian Names:_____

Address:_____

Home Phone:_____

Cell Phone:_____

Please check days and fill in approximate times needed:

Monday _____ _____

Tuesday _____ _____

Wednesday _____ _____

Thursday _____ _____

Friday _____ _____

*Registration Fee is $25.00 per family.

Parent or Guardian Signature:_____Date:_____