St. Theresa Catholic School

6311 Baseline Rd
Little Rock, AR 72209

Phone: 501-565-3855
Fax: 501-565-9522
Email: schooloffice@stslr.org

CARE APPLICATION

Weekly Fees will be drafted. Registration yearly $25 Per student $8.00 afternoon $2.00 morning

Student Information:

Student Name _____
Last First Middle
DOB___/___/___ M____F____ SS# ____/____/____ Religion_____
Grade Level ____

Family Information*:*

Mailing Name _____
Address _____Zip Code _____
Home Phone _____Parish _____How long _____

Parent/Guardian:

Relationship _____ Sex ____ Relationship _____Sex_____
Name_____ Name _____
Business_____ Business _____
Bus. Phone _____Cell_____ Bus. Phone _____ Cell _____
Religion _____ Religion _____
Marriage Status _____ Marriage Status _____

Persons other than parent/guardian to contact *:*

1st Contact 2nd Contact:
Name _____ Name _____
Home #_____Bus. #_____ Home # _____ Bus.# _____
Cell # _____ Cell# _____
Relationship_____ Relationship _____
++
Family Doctor _____ Phone Number_____
Family Dentist _____ Phone Number _____
Insurance Name_____ Policy Number _____
Allergies or special conditions _____
I hereby give my consent for my child to be released to the following: _____
_____

Consent for Emergency Medical Care of

_____

I hereby request and give consent to the Director of St. Theresa's Care or her appointed representative, for said child/children to receive such medical or surgical care as may be deemed necessary and expedient by a licensed or recognized physician or surgeon in case of an emergency when the parent/guardian or the person listed as emergency contact cannot be reached.

_____ _____
Parent/Guardian Date Parent/.Guardian Date