



Our Lady of MT Carmel School  
 EXTENDED CARE PROGRAM  
 205 Oak Street  
 Boonton, New Jersey 07005  
 Telephone: 973.334.2777  
 FAX: 973.334.0975  
 Website: [www.olmcboonton.org](http://www.olmcboonton.org)

EXTENDED CARE PROGRAM YEAR 2009 – 2010 APPLICATION

I, \_\_\_\_\_ hereby make application for the admission of  
 \_\_\_\_\_ to the Extended Care Program at Our Lady of Mt. Carmel.

Child's Name (Last)	(First)	Date of Birth	Grade
---------------------	---------	---------------	-------

Address (Street, Town, Zip Code)	Home Phone Number
----------------------------------	-------------------

FATHER (or GUARDIAN) \_\_\_\_\_

OCCUPATION \_\_\_\_\_

EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_

TELEPHONE, CELL, OR BEEPER \_\_\_\_\_

MOTHER (or GUARDIAN) \_\_\_\_\_

OCCUPATION \_\_\_\_\_

EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_

TELEPHONE, CELL, OR BEEPER \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

**WHEN UNABLE TO REACH ME IN ILLNESS OR EMERGENCY, I AUTHORIZE THE COUNSELORS TO CONTACT:**

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

**LIST ANY/ALL ALLERGIES YOUR CHILD HAS IN DETAIL:** \_\_\_\_\_

**LIST ANY/ALL MEDICATION/PROCEDURES TO BE FOLLOWED WITH REGARDS TO YOUR CHILD'S ALLERGY(IES):** \_\_\_\_\_

**I GIVE MY CONSENT AND PERMISSION TO THE PERSON IN AUTHORITY TO SEEK THE NEAREST MEDICAL CARE IN EXTREME EMERGENCY AND TO CONTACT MY CHILD'S DOCTOR IN ANY EMERGENCY.**

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

Address: \_\_\_\_\_

**PLEASE MARK WHICH PAYMENT SHCEDULE YOU REQUIRE:**

Monthly Payment of \$200.00 per month

Hourly Rate Card cost \$70.00 / 7 hours

\_\_\_\_\_ yes

\_\_\_\_\_ yes

A fee sheet has been attached which may assist you in planning which payment plan right for you. If you should have further questions, please contact us directly.

I UNDERSTAND THAT I AM RESPONSIBLE FOR EACH PAYMENT I SIGNED UP FOR IN ADVANCE OF SERVICE, WHETHER OR NOT MY CHILD IS OUT OF SCHOOL BECAUSE OF ILLNESS OR FOR PERSONAL REASONS. THIS IS THE ONLY WAY WE CAN HOLD YOUR CHILD'S PLACE IN OUR PROGRAM AND PLAN FOR ADEQUATE STAFFING. IN ADDITION, BEFORE ADMISSION OF MY CHILD INTO THE PROGRAM THE FIRST MONTH'S PAYMENT, REGISTRATION AND SUPPLY FEES ARE DUE IN ADVANCE. I UNDERSTAND THAT THERE WILL BE A LATE FEE FOR ANY UNPAID BALANCE PAST THE 10<sup>TH</sup> OF EACH MONTH.

AS LEGAL GUARDIAN, I HEREBY RECOGNIZE THAT THE OUR LADY OF MT. CARMEL SCHOOL EXTENDED CARE PROGRAM STAFF IS NOT RESPONSIBLE FOR INJURIES SUSTAINED WHILE PARTICIPATING IN INDOOR OR OUTDOOR ACTIVITIES, THEREFORE, FOREVER RELEASE THE OUR LADY OF MT. CARMEL EXTENDED CARE PROGRAM, ITS AGENTS, SERVANTS AND/OR EMPLOYEES FROM ANY AND ALL INJURIES AND /OR DAMAGES INCLUDING MEDICAL EXPENSES, SUFFERED AND/OR INCURRED BY MY CHILD WHILE ENROLLED IN THE OUR LADY OF MT. CARMEL SCHOOL EXTENDED CARE PROGRAM.

**THIS WAIVER OF LIABILITY IS SIGNED VOLUNTARILY AS TO ITS CONTENTS AND INTENT.**

SIGNATURE OF PARENT/GUARDIAN: \_\_\_\_\_ DATE: \_\_\_\_\_