Holy Rosary School Extended Care

770 Aloha Street
Edmonds, WA 98020

Enrollment and Contact Data

	Child's Last Name	First	Middle	Date of Birth	Grade
1.					
2.					
3.					

Parent/Guardian	**Parent/Guardian**
Name	Name
Address	Address
City Zip	City Zip
Email	Email
Phone	Phone

Persons authorized to sign my child out of Extended Care If someone other than you (parents/guardian) or authorized persons listed below are to pick up your child, you must notify the director and provide written permission. Photo ID required.	
Name	Name
Relationship	Relationship
Address	Address
City Zip	City Zip
Cell phone	Cell phone
Name	Name
Relationship	Relationship
Address	Address
City Zip	City Zip
Cell phone	Cell phone

Emergency Contacts (should be familiar with your child's medical status)	
Name	Name
Relationship	Relationship
Address	Address
City Zip	City Zip
Cell phone	Cell phone
Please inform the persons listed above that they will be contacted in the event of an **emergency** if the parent or guardian is unreachable, and they may be asked to pick up your child from Extended Care.	

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Financial Agreement and Tuition Rates | 2026-2027

Holy Rosary Extended Care provides different attendance options. Please carefully consider your circumstances, and then select the option(s) that best suits your needs.

Non-refundable annual registration fee is $100.00 per Family

Attendance Options	Tuition Rates monthly/per child		
1) Afternoons (1:30[Mon]/3:15pm – 6pm)	**1 day per week** $155.00/month	**2-3 days per week** $308.00/month	**4-5 days per week** $420.00/month
Select attendance option:	☐	☐	☐
Select the days of week for attendance:			
Mon ☐	Tue ☐	Wed ☐	Thu ☐	Fri ☐

2) Occasional Use/Drop-In:	**With 24-hour advance arrangement**
Drop-in Monday	$40.00/day
Drop-in Tue-Fri	$25.00/day
Or a non-regular basis select Drop-In:	Drop-In Only ☐

Billed as used and dependent on space availability.

Contract:

We/I agree to pay the full non-refundable monthly tuition or drop-in rate as posted to my/ our Tuition Billing Management account(s). We/I understand our payment is subject to the terms and conditions of our Tuition Billing Management account. Late fees and NSF fees will apply to payments as defined in the Holy Rosary Enrollment contract.

Picking up a child after 6:00 PM will result in a charge of $1.00 per minute according to the Extended Care clock. There will be no refund or credits when a child is absent for any reason. The full monthly payment selected will be charged regardless of actual usage. Tuition is not pro-rated for any reason. If Extended Care is in session 10 days or less a month, tuition is reduced to ½ the normal monthly rate.

If more than one parent is responsible for payment, an agreement will need to be made with each party before your child can be accepted in the Holy Rosary Extended Care Program.

Person Responsible for Payment		
Parent/Guardian Name:		
Parent/Guardian Signature		**Date**
Address	**City**	**Zip**
Home email	**Home phone**	
Cell phone		

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Medical Information

1st Child's Last Name	First	Middle	Date of Birth	Grade

Current medical information enables Extended Care staff to provide informed care for your child. **Please enter all the fields below.**

Your Child's Medical Professional Contact Data			
Medical Insurance Company		**Policy number**	
	Name	Phone number	Address
Physician			
Dentist			
Hospital			

List the current medications and supplements for your child	
Medication/Supplement Name	Notes

Current Health Survey and Questionnaire	
Disability, Disease, or Life Threatening Condition: Please specify. • Related Information:	
Medical Devices installed/used (braces, hearing aids, etc.) Please specify. • Related information:	
Allergies with medical consequences: Please specify. • Expected symptoms: • Method of treatment if necessary:	
Developmental Difficulties: Please specify: • Related information:	
• Family history of: Allergies Asthma Diabetes Epilepsy Other:	
Date of last hospitalization	Reason
Date of last physical exam	Date of last dental exam
Date of last vision exam	Date of last hearing exam
If there is anything else you would like to share about your child, please use a separate piece of paper and attach to this document.	

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Medical Information – Consent for Treatment

1st Child's Last Name	First	Middle	Date of Birth	Grade

Consent to Medical Treatment of Minor Children
I (Parent/Legal Guardian) _____, hereby give permission for my child, _____, to be given emergency treatment, including first aid and CPR, by a qualified staff member at Holy Rosary Extended Care. If I cannot be contacted, I further authorize and consent to medical, surgical, and hospital care, treatment and procedures to be performed by my child's regular physician, or when that physician cannot be reached, by a licensed physician or hospital when deemed necessary or advisable by a physician to safeguard my child's health. I waive my right of informed consent to treatment. I give permission for my child to be transported by ambulance or aid car to the hospital to receive treatment. I agree to pay all costs and fees contingent on any emergency medical care and/or treatment for my child as secured or authorized under this consent.
Parent/Guardian signature: Date:
Parent/Guardian signature: Date:

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Medical Information

2nd Child's Last Name	First	Middle	Date of Birth	Grade

Current medical information enables Extended Care staff to provide informed care for your child. **Please enter all the fields below.**

Your Child's Medical Professional Contact Data			
Medical Insurance Company		**Policy number**	
	Name	Phone number	Address
Physician			
Dentist			
Hospital			

List the current medications and supplements for your child	
Medication/Supplement Name	Notes

Current Health Survey and Questionnaire	
Disability, Disease, or Life Threatening Condition: Please specify. • Related Information:	
Medical Devices installed/used (braces, hearing aids, etc.) Please specify. • Related information:	
Allergies with medical consequences: Please specify. • Expected symptoms: • Method of treatment if necessary:	
Developmental Difficulties: Please specify: • Related information:	
• Family history of: Allergies Asthma Diabetes Epilepsy Other:	
Date of last hospitalization	Reason
Date of last physical exam	Date of last dental exam
Date of last vision exam	Date of last hearing exam
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Parent/Guardian signature: Date:
Parent/Guardian signature: Date:

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Medical Information

3rd Child's Last Name	First	Middle	Date of Birth	Grade

Current medical information enables Extended Care staff to provide informed care for your child. **Please enter all the fields below.**

Your Child's Medical Professional Contact Data			
Medical Insurance Company		**Policy number**	
	Name	Phone number	Address
Physician			
Dentist			
Hospital			

List the current medications and supplements for your child	
Medication/Supplement Name	Notes

Current Health Survey and Questionnaire	
Disability, Disease, or Life Threatening Condition: Please specify. • Related Information:	
Medical Devices installed/used (braces, hearing aids, etc.) Please specify. • Related information:	
Allergies with medical consequences: Please specify. • Expected symptoms: • Method of treatment if necessary:	
Developmental Difficulties: Please specify: • Related information:	
• Family history of: Allergies Asthma Diabetes Epilepsy Other:	
Date of last hospitalization	Reason
Date of last physical exam	Date of last dental exam
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3rd Child's Last Name	First	Middle	Date of Birth	Grade

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Parent/Guardian signature: Date:
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