

# **Welcome to Pius Pals!**



**In this packet you will find Enrollment forms that must be returned to the Pius Pals' Director on your first day of care. The Pius Pals Director's name is Brittany Smith and can be reached by email or phone.**

**[bsmith@stpiusxschool.org](mailto:bsmith@stpiusxschool.org)**

**515-829-7461**

# SPX Pius Pals Enrollment Form

2018–2019 School Year

Session Selection: \_\_\_\_\_

Before School: 7:00AM – 7:50AM

After School: 3:00PM – 6:00PM

BOTH

Child's Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: (h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_

Place of Work: \_\_\_\_\_

Father's Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: (h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_

Place of Work: \_\_\_\_\_

Email address you want to use for Pius Pals communication (please write your most checked email address to stay in tune with important details):

1) \_\_\_\_\_ 2) \_\_\_\_\_

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Parent Signature

Date

# SPX Pius Pals Child Emergency Form

## 2018–2019 School Year

\*\*\*\*\*MUST BE COMPLETED FOR REGISTRATION\*\*\*\*\*

Emergency Contacts: (Parents will always be notified first)

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

Dentist Name: \_\_\_\_\_ Phone: \_\_\_\_\_

As a parent/guardian, I do hereby authorize treatment by a qualified and licensed physician of the following minor in the event of a medical emergency which, in the opinion of the attending physician, may endanger the minor's life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after reasonable effort has been made to reach me.

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Parent Signature

Date

**All emergency contacts MUST show up with a photo I.D**

# SPX Pius Pals Child Pick Up Permission Form

## 2018–2019 School Year

My child/ren may be released to the following individuals:

All The Emergency Contacts listed above. (Please check if this applies)

And/Or the following people:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

My child **CAN NOT** be released to the following person:

Name: \_\_\_\_\_

**If the above person is a biological parent, court papers must be on file with Pius Pals records/school office showing that the child may not be released to that parent. Parent must show a photo I.D**

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Parent Signature

Date

**SPX Pius Pals Prescription/OTC Medication  
Authorization Form  
2018-2019 School Year**

Student's Name\_\_\_\_\_

Age\_\_\_\_\_ Grade\_\_\_\_\_ Teacher\_\_\_\_\_

Physician Name\_\_\_\_\_ Phone\_\_\_\_\_

Dentist Name\_\_\_\_\_ Phone\_\_\_\_\_

Pharmacy\_\_\_\_\_

Diagnosis (what is this medication for?)\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Amount to be given:\_\_\_\_\_ Time to be given\_\_\_\_\_

Is this medication to be given "as needed": \_\_ or at a specific time\_\_ (please check one)

Start date\_\_\_\_\_ Ending date:\_\_\_\_\_

Amount sent to Pius Pals: \_\_\_\_\_

**I request that the prescribed drugs, medication (s), OTC medication (s), topical ointment is dispensed according to these written instructions. I request that a qualified Pius Pals person give this medication. The student has experienced no previous side effects from the medication. I further agree that Pius Pals personnel may contact the prescriber as needed and that medication information be shared with Pius Pals personnel who need to know.**

Parent signature \_\_\_\_\_ Date\_\_\_\_\_

Work phone \_\_\_\_\_

Cell phone \_\_\_\_\_

**MEDICATION WILL NOT BE GIVEN IF MEDICATION IS NOT IN ITS ORIGINAL PRESCRIPTION BOTTLE, HAS EXPIRED OR IF IT HAS AN IMPROPER LABEL. PLEASE CHECK YOUR CONTAINER BEFORE SENDING IT TO PIUS PALS.**

# SPX Pius Pals Allergies/Medical Concern Form

## 2018–2019 School Year

My child \_\_\_\_\_ has allergies to the following

_____	_____
_____	_____
_____	_____

My child \_\_\_\_\_ has allergies to the following

_____	_____
_____	_____
_____	_____

My child \_\_\_\_\_ has allergies to the following

_____	_____
_____	_____
_____	_____

**\*\* PLEASE INCLUDE ANY ADDITIONAL INFORMATION ABOUT YOUR CHILD'S ALLERGY THAT WE MAY NEED TO KNOW ABOUT\*\***

**\*\*If snack is served with a possible allergic reaction, parent can provide a personal snack for that child/ren or Pius Pals will provide an appropriate snack.\*\***

**SPX Pius Pals Photograph, Published In Various  
Media Outlets Authorization Form**  
**2018–2019 School Year**

I, \_\_\_\_\_, give SPX Pius Pals School Program  
permission to photograph and publish my child, \_\_\_\_\_,  
and use the resulting photographs for any purpose of SPX Pius Pals that deems proper.

I, \_\_\_\_\_, give SPX Pius Pals School Program  
permission to photograph and publish my child, \_\_\_\_\_,  
and use the resulting photographs for any purpose of SPX Pius Pals that deems proper.

I, \_\_\_\_\_, give SPX Pius Pals School Program  
permission to photograph and publish my child, \_\_\_\_\_,  
and use the resulting photographs for any purpose of SPX Pius Pals that deems proper.

Parent signature \_\_\_\_\_ Date \_\_\_\_\_



