

**OUR SAVIOR LUTHERAN SCHOOL  
EXTENDED DAY CARE APPLICATION**

Please complete BOTH SIDES of this form (leaving NO blanks) and return it to a Day Care staff member to reserve a space for your child. Virginia State requires that there are two emergency contacts for each child.

Program Desired  
(Please mark both AM and PM if applicable)

Times	AM	PM
	/ / 7:00 – 8:15	/ / 3:00 – 4:00
	/ / 7:30 – 8:15	/ / 3:00 – 5:00
		/ / 3:00 – 6:00

Child's Name: \_\_\_\_\_

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

Grade: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Allergies or intolerance to food, medications, etc... \_\_\_\_\_

\_\_\_\_\_

Child's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Adult Contacts (other than parents) in case of Emergency: Please fill in both spaces

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

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

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

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

Person(s) Authorized to pick up child:

\_\_\_\_\_

Person(s) NOT Authorized to pick up child: (Attach appropriate paperwork) \_\_\_\_\_

\_\_\_\_\_

Mother's Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address (if different): \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Normal Work Hours: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address (if different): \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Normal Work Hours: \_\_\_\_\_

Legal Custodian (other than parent): \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Normal Work Hours: \_\_\_\_\_

#### Agreements

1. The extended Day Care agrees to notify the parent/guardian whenever the child becomes ill, and the parent/guardian agrees to pick up the child thereafter as soon as possible.
2. The parent/guardian authorizes the extended day care center to obtain immediate medical care if any emergency occurs when he/she cannot be located immediately.

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_  
(signature)

Date Child Entered Care: \_\_\_\_\_ Left Care: \_\_\_\_\_

OSLS office has child's health records on file. Staff initials \_\_\_\_\_

#### OFFICE USE ONLY IDENTITY VERIFICATION

Place of Birth	Birth Date	Birth Certificate Number	Date Issued
Other Form of Proof			