LAST NAME: _____ DATE REC'D: _____ CONFIRMED: _____

SAINT JOSEPH SCHOOL

Aftercare Program

2024-2025 Enrollment Contract

Please check each item.

☐ I agree to the monthly set schedule on this form for the full 2024-2025 school year. Any request for a change of schedule will only be made monthly and are due prior to the first of the month. If additional days are requested for the school year, it is subject to availability and approval by the Director. After approval of new days and times a new enrollment form will be submitted and the classroom teacher will be notified of dismissal plan changes.

☐ I understand that the schedule is staffed by teachers based on the enrollment for each day; therefore it is not permitted to drop-in or swap days.

☐ I will adhere to the scheduled pick up times of 4:00pm and 5:30pm. It is my responsibility if running late to notify the Director, and to call authorized alternate people on my pick-up list. If the child is not picked up by his or her scheduled pickup time, a late fee of $15.00 for every 15 minutes or portion thereof, will be added to next month's invoice.

☐ All fees will be sent to your FACTS incidental expenses account on the 15th of each month and are due by the 25th of each month based on the number of days per week contracted.

☐ Monthly Fees are based on 36-weeks of school and divided into 10-equal payments. Monthly fees are not adjusted for illness, COVID-19-related remote learning, holidays, after school clubs, snow days, family vacations or other closing beyond the school's control.

☐ Families with more than one child in the Aftercare program receive an 5% discount on the monthly rate of each additional child.

☐ After you return your Aftercare contract, we will charge your FACTS account $100.00 per child to reserve your spot.

Parent Signature _____

Printed Name _____

Date _____

Total Monthly Aftercare Fee _____

2024-2025 ENROLLMENT SCHEDULE

DATE REC'D: _____

PARENT NAME
TELEPHONE #
EMAIL ADDRESS

*** Please notify the **classroom teacher** of any dismissal plan changes.***

PLEASE CHECK THE DAY(S) FOR ENROLLMENT

	STUDENT'S NAME	GRADE	2:30 – 4PM	2:30 – 5:30PM
FIRST CHILD	MONDAY		☐	☐
	TUESDAY		☐	☐
	WEDNESDAY		☐	☐
	THURSDAY		☐	☐
	FRIDAY		☐	☐
	TOTAL DAYS PER WEEK			
	MONTHLY FEE – 1ST CHILD			
	STUDENT'S NAME	GRADE	2:30 – 4PM	2:30 – 5:30PM
SECOND CHILD	MONDAY		☐	☐
	TUESDAY		☐	☐
	WEDNESDAY		☐	☐
	THURSDAY		☐	☐
	FRIDAY		☐	☐
	TOTAL DAYS PER WEEK			
	MONTHLY FEE – 2ND CHILD			
	STUDENT'S NAME	GRADE	2:30 – 4PM	2:30 – 5:30PM
THIRD CHILD	MONDAY		☐	☐
	TUESDAY		☐	☐
	WEDNESDAY		☐	☐
	THURSDAY		☐	☐
	FRIDAY		☐	☐
	TOTAL DAYS PER WEEK			
	MONTHLY FEE – 3RD CHILD			
		TOTAL MONTHLY FEE		

AFTERCARE PROGRAM MONTHLY FEE SCHEDULE					
4:00PM		2-DAYS	3-DAYS	4-DAYS	5-DAYS
one child		$120	$180	$240	$300
each additional child		$114	$171	$228	$285
5:30PM		2-DAYS	3-DAYS	4-DAYS	5-DAYS
one child		$185	$295	$405	$515
each additional child		$176	$280	$385	$489

SAINT JOSEPH SCHOOL

Aftercare Program

2024-2025 Pickup Authority

I _____ give the following people the authority to pick my child/ren _____ from Aftercare.

NAME	RELATIONSHIP TO CHILD
1	
2	
3	
4	
5	

Signature of Parent/Guardian:_____

Any person not listed on this form will NOT be allowed to pick your child up from Aftercare unless a new form is filled out or an email is sent to the Aftercare Director from the parent/guardian with specific instructions.

SAINT JOSEPH SCHOOL

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2024-25 EMERGENCY DISMISSAL INFORMATION

One per family

In an emergency situation, it may become necessary for us to dismiss students prior to the end of the school day. Please fill in the following information that will assist us in contacting you should it be necessary. We will attempt to contact you via phone and e-mail.

Student Last Name	Student First Name	Birthdate	Homeroom
Street Address	Town	Zip	
Home Phone	Email		
Mother's Name	Mother's Cell Phone	Mother's Work Phone	
Father's Name	Father's Cell Phone	Father's Work Phone	
Student's Normal Mode of Transportation	☐ CAR ☐ BUS ☐ DAYCARE ☐ WALK		

In the event that we are not able to reach you or you are not able to pick up your child, please provide the names of two people who we can release your child to and who will assume temporary care.

Name	Relationship	
Home Phone	Work Phone	
Address		
Name	Relationship	
Home Phone	Work Phone	
Address		

I give permission to release my child into the custody of the persons named above. _____
sign/date

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his/her instructions. If it is impossible to contact this physician, the school may make whatever arrangements seem necessary. _____
sign/date

Remarks	
Allergies	
Other Conditions	
Local Physician's Name	Address
Office Phone	Other Phone

SAINT JOSEPH SCHOOL

Aftercare Program

2024–2025 HEALTH HISTORY

One per child

Student Last Name	Student First Name	Birthdate	Age
Entering Grade	Teacher		Male/Female

PRENATAL / INFANCY

Was child born full term? Y / N	If premature, how many weeks early?	Birth weight
Were there any problems during labor, birth or early infancy? Y / N If yes, please explain		

MEDICAL HISTORY Does your child have allergies? Y / N If yes, please explain

ALLERGIC to:

PLANT ☐	ANIMAL ☐	FOOD ☐	BEE/INSECT ☐	MEDICATION ☐	ENVIRONMENT ☐	OTHER ☐
Type of Reaction:		LOCAL ☐		ANAPHYLACTIC ☐		
Required Response:	EPI-PEN ☐		EPI-PEN JR. ☐	BENADRYL ☐	OTHER	

ILLNESS OR DEVELOPMENT PROBLEMS NONE please check any of the following that the child has:

1. Asthma ☐	7. Convulsions/Seizures ☐	13. Ear Infections ☐	19. Skin ☐
2. Bleeding ☐	8. Cystic Fibrosis ☐	14. Heart Problems ☐	20. Speech ☐
3. Bone / Muscle ☐	9. Cerebral Palsy ☐	15. Hearing ☐	21. Stomach ☐
4. Bowel ☐	10. Dental ☐	16. Meningitis ☐	22. Urinary / Bladder ☐
5. Cancer / Leukemia ☐	11. Diabetes ☐	17. Sickle Cell Anemia ☐	23. Special Diet ☐
6. Attention / Learning ☐	12. Emotional / Behavioral ☐	18. Vision ☐	24. Special Equipment ☐

For those illnesses or developmental problems checked above and any other surgery, hospitalization, injury/accident, family history, or other significant past or present medical problem, please provide additional information. Use the reverse side if needed.

Does your child take **MEDICATION** on a regular basis? Y / N If yes, please list:

Medication	Dose	Time of Day Taken
Medication	Dose	Time of Day Taken

May your child fully participate in recess/physical education? Y / N If no, please explain restrictions

Do you have any other health information regarding your child that the school nurse should know? Y / N (ex: recent changes in child's life)

Please explain if yes, and use the reverse side if necessary.

Signature _____ Relationship _____ Date _____