

SAINT JOSEPH SCHOOL

# Aftercare Program

## 2020-2021 Enrollment Contract

Please check each item

- I agree to the monthly set schedule on this form for the full 2020-2021 school year. A two week notice is required to change my child's schedule for the school year. 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 4:00 p.m. and 6:00 p.m. 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 are due by the first of the month and are based on the number of days per week contracted. Fees will be charged through FACTS. See fee schedule form.
- Fees for the months of December, February and April will be pro-rated to 75% of the monthly fee to reflect one week of school vacation during those months. Otherwise, monthly fees are not adjusted for illness, 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 8% discount on the monthly rate of each additional child.
- After you return your Aftercare contract, we will charge your FACTS account \$100.00 to reserve your spot.

Parent Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

Date \_\_\_\_\_

Total Monthly Aftercare Fee \_\_\_\_\_

# 2020-2021 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

**FIRST CHILD**

STUDENT'S NAME	GRADE	2:30 - 4PM	2:30 - 6PM
MONDAY			
TUESDAY			
WEDNESDAY			
THURSDAY			
FRIDAY			
TOTAL DAYS PER WEEK			
MONTHLY FEE – 1 <sup>ST</sup> CHILD			

**SECOND CHILD**

STUDENT'S NAME	GRADE	2:30 - 4PM	2:30 - 6PM
MONDAY			
TUESDAY			
WEDNESDAY			
THURSDAY			
FRIDAY			
TOTAL DAYS PER WEEK			
MONTHLY FEE – 2 <sup>ND</sup> CHILD			

**THIRD CHILD**

STUDENT'S NAME	GRADE	2:30 - 4PM	2:30 - 6PM
MONDAY			
TUESDAY			
WEDNESDAY			
THURSDAY			
FRIDAY			
TOTAL DAYS PER WEEK			
MONTHLY FEE – 3 <sup>RD</sup> CHILD			

<b>TOTAL MONTHLY FEE</b>	
--------------------------	--

<b>AFTERCARE PROGRAM MONTHLY FEE SCHEDULE</b>					
4:00PM	1- DAY	2-DAYS	3-DAYS	4-DAYS	5-DAYS
one child	\$55	\$110	\$165	\$220	\$275
each additional child	\$51	\$102	\$153	\$204	\$255
6:00PM	1-DAY	2-DAYS	3-DAYS	4-DAYS	5-DAYS
one child	\$113	\$226	\$339	\$452	\$565
each additional child	\$103	\$206	\$309	\$412	\$515

SAINT JOSEPH SCHOOL

# Aftercare Program

## 2020-2021 Car 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

# Aftercare Program

## 2020-21 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	<input type="checkbox"/> CAR	<input type="checkbox"/> BUS	<input type="checkbox"/> DAYCARE <input type="checkbox"/> 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

## 2020-2021 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. Ashtma	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 \_\_\_\_\_