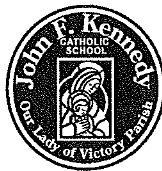
PARENTS: To complete this registration, we will need:
_____ Registration form
_____ Student Information Sheet
_____ Assessment and Health Form
_____ Immunization certificate

2020-21



School-Age refers to students in Kindergarten through a student's 13th birthday.

JFK After School Care for School-Age Students
Kindergarten – 12 years of age
Program Registration Form

One form is required for each child.

Child's Name______________________ Birthdate______________ Grade____________

Address____
Street Address City State Zip Code

Parent/Guardian Name(s)____

Mother's Cell Phone_______________________ Father's Cell Phone_______________________

Mother's Work Phone_______________________ Father's Work Phone_______________________

Mother's E-mail_______________________ Father's E-mail_______________________

AFTER SCHOOL CARE	
REGISTRATION FEE: $25 PER CHILD	
RATES: Each Child: $1.60 per 15 minutes ($6.40 per hour)	
PAYMENT METHOD: Payment will be pulled every other week from your established childcare account. (See **Childcare Account** below.) **Childcare statements are sent VIA backpack mail.**	
LOCATION: After School Care for school age students is held in the lunchroom inside the main entrance of the school. **HOURS OF OPERATION:** M-T-TH-F 2:40-5:30 p.m. WEDNESDAY 1:40-5:30 p.m.	**PICK UP:** Enter through the school's main entrance on 42nd Street. Ring the doorbell to the right of the doors to gain entry. The child must be signed out of our care by an authorized person who is listed on the Student Information Sheet.

CHILD CARE ACCOUNT:
A child care account must be established by every family using JKF Child Care Services. This can be accomplished by making an initial deposit on the day of registration of an estimated amount to cover the cost of the first two weeks of child care expenses. Families are expected to continue to make regular deposits into this account in one of these manners:

1) Continue to make bi-weekly deposits to cover the estimated expenses for child care
2) Pay the bi-weekly statement in full the week it is sent home.
3) Make a deposit/payment using your debit/credit card. A 1% fee will be added.

OTHER FEES
LATE PICK-UP FEE: The hours of operation for After School Care are from 2:40-5:30pm (1:40-5:30pm on Wed.) When you are late picking up, a fee of $2.00 per child per every 5 minutes past 5:30 will be charged to your child care account.

RETURNED CHECK FEE: If a payment check is returned due to insufficient funds, your child care account will be charged $10.00.

I understand that school rules and policies of JFK School apply to students enrolled in JFK Child Care Services.

I understand and agree that the violation of these rules and policies and/or non-payment of fees may result in my child not being allowed to attend the child care programs at John F. Kennedy School.

I understand that access to child care may be terminated for any family who fails to pay for childcare services.

Parent Signature: ____ Date____________________

____ Date: ____________________
Signature: JFK Principal/Director of JFK Child Care Services

JFK CHILDCARE SCHOOL AGE STUDENT INFORMATION FORM WITH EMERGENCY MEDICAL CONSENT

CHILD'S NAME:		BIRTH DATE:
PARENT(S)/GUARDIAN(S) WITH WHOM THE CHILD RESIDES		
1. NAME	RELATIONSHIP TO CHILD	
ADDRESS		
HOME NUMBER	CELL NUMBER	WORK NUMBER
2. NAME	RELATIONSHIP TO CHILD	
ADDRESS		
HOME NUMBER	CELL NUMBER	WORK NUMBER
EMERGENCY CONTACTS/PERMISSION TO PICK UP – INCLUDE YOURSELF		
1. NAME	☐ EMERGENCY CONTACT AND PICK UP	☐ PICK UP ONLY
HOME PHONE	CELL PHONE	WORK PHONE
2. NAME	☐ EMERGENCY CONTACT AND PICK UP	☐ PICK UP ONLY
HOME PHONE	CELL PHONE	WORK PHONE
3. NAME	☐ EMERGENCY CONTACT AND PICK UP	☐ PICK UP ONLY
HOME PHONE	CELL PHONE	WORK PHONE
4. NAME	☐ EMERGENCY CONTACT AND PICK UP	☐ PICK UP ONLY
HOME PHONE	CELL PHONE	WORK PHONE
5. NAME	☐ EMERGENCY CONTACT AND PICK UP	☐ PICK UP ONLY
HOME PHONE	CELL PHONE	WORK PHONE

Custody or restraining orders for a person(s) who may attempt to pick up or have contact with the child while in care at the center. A copy of the court order(s) must be provided to JFK Child Care Services.

Name	Name

PHYSICIAN NAME	DENTIST NAME
PHONE NUMBER	PHONE NUMBER
ADDRESS	ADDRESS
HOSPITAL PREFERENCE	
KNOWN ALLERGIES	
DAILY MEDICATIONS	
INSURANCE COMPANY	POLICY IDENTIFICATION NUMBER

This form allows parents and guardians to authorize the provision of emergency treatment for below named child who becomes ill or injured while under program authority when parents or guardians cannot be reached. In the event reasonable attempts to contact have been unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by the doctor or dentist listed below, or if unavailable, another licensed physician or dentist.

I agree to pay all costs and fees as secured or authorized under this consent.

This consent will be in effect for one year, beginning on the date signed, and updated annually thereafter.

SIGNATURE OF PARENT OR GUARDIAN　　　　　　　　DATE

JFK CHILD CARE SERVICES
SCHOOL-AGE ASSESSMENT & HEALTH FORM
TO BE COMPLETED BY PARENT/GUARDIAN

HEALTH STATEMENT

Child's Full Name ______________________________ Birth Date ________________

1. Significant illnesses and surgeries child has had (give age at time):

____

2. Any special health-related needs of child (allergies, medications, injuries, etc.):

____

____

3. Will your child need access to medications (prescription or over-the-counter) while in childcare?

____

PHYSICAL ASSESSMENT

1. Are there any problems with vision, hearing or speech of which the child care program should be aware or could accommodate by appropriate action?

____

____

2. Is this child subject to any conditions which limit classroom activities or physical education?

____

3. Is this child subject to any condition which may result in an emergency situation?

____

4. Is this child subject to any mental or physical condition for which he/she should remain under periodic medical observation?

____

____

5. Other information you would like to share:

____

____

____

FOR CENTERS SERVING SCHOOL-AGE CHILDREN OPERATING IN THE SAME SCHOOL FACILITY IN WHICH THE CHILD ATTENDS SCHOOL:
My signature below certifies that immunization information concerning my child has been provided and is available in the school file.

Parent's Signature ______________________________ Date ______________________