PARENTS: To complete this registration, we will need:

_____ Registration form

_____ Student Information Sheet

_____ Assessment and Health Form

_____ Immunization certificate

2023-24

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: $5.00 per hour	
LOCATION: After School Care for school age students is held in the lunchroom inside the main entrance of the school. **HOURS OF OPERATION:** M-F 2:40-5:30 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.

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 $15.00 per child per every 15 minutes past 5:30 will be charged to your child care account.

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		EMAIL
HOME NUMBER	CELL NUMBER	WORK NUMBER
2. NAME		RELATIONSHIP TO CHILD
ADDRESS		EMAIL
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:_____

Injuries:_____

Other:_____

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?
Vision:_____

Hearing:_____

Speech:_____

2. Is this child subject to any conditions which limit tabletop activities or outdoor play?

_____

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

_____

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 _____