



Academy of St. Adalbert

56 Adalbert Street * Berea * Ohio * 44017 * 440-234-5529

ACADEMY OF ST. ADALBERT EXTENDED DAY PROGRAM

REGISTRATION AGREEMENT

1. I understand that each new school year I must register and complete all forms.
2. I understand that during school vacation and days when school is closed because of bad weather, the Academy of St. Adalbert Extended Day Program will not be in session.
3. I understand that in addition to a non-refundable registration fee of \$25.00 per family (due at time of registration) the charges for the Academy of St. Adalbert Extended Day Program are \$3.00 per hour (minimum one hour) for one child and \$2.00 per hour for each sibling.
4. I understand that dismissal time will be no later than 6:00PM and that **A LATE FEE OF \$3.00 WILL BE CHARGED FOR EACH FIFTEEN (15) MINUTE INCREMENT AFTER 6:00PM PAYABLE TO STAFF MEMBER INCONVENIENCED.**
5. I understand that a fee of \$8.00 will be charged for returned checks.
6. I understand that all checks should be made payable to: **St. Adalbert Extended Day Care Program.**
7. I understand that my child/children will be released only to the person(s) designated on the "Child Pick-Up Authorization" form and that a picture ID must be shown daily.
8. If a medical emergency arises, the program staff will first attempt to contact me. If I cannot be reached, the staff will contact those named as emergency contacts. If they cannot be reached, the staff will contact the child's doctor. If the emergency is such that immediate hospital attention is necessary, such arrangements will be made. I release the Academy of St. Adalbert Extended Day Program staff from liability in carrying out emergency procedures.

**I AGGREE TO ADHERE TO THE ABOVE EXTENDED DAY PROGRAM
REGISTRATION POLICIES AND GIVE MY CHILD PERMISSION TO PARTICIPATE
FULLY IN THIS PROGRAM.**

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

ACADEMY OF ST. ADALBERT EXTENDED DAY PROGRAM

ADMISSION INFORMATION

Registration Fee: \$25.00

Date Paid: _____ **Date Enrolled:** _____

Child's Name: _____ Birthday: _____

Home Address: _____ Home Phone: _____

Mother's Name: _____

Home Address: _____ Home Phone: _____

Business Address: _____ Bus. Phone: _____

Cell Phone: _____

Pager: _____

Father's Name: _____

Home Address: _____ Home Phone: _____

Business Address: _____ Bus. Phone: _____

Cell Phone: _____

Pager: _____

If parents cannot be reached in the event of an emergency, please contact: (two names)

NAME	ADDRESS	PHONE	RELATIONSHIP
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_____	_____	_____	_____
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List all allergies and any special precautions or treatments indicated for these allergies:

List any medications currently being administered to the child:

List any chronic physical problems and history of hospitalization:

Date of last tetanus shot: _____

List any diseases the child has: _____

Child's physician and/or clinic: _____

Doctor's Address: _____

Doctor's Phone: _____

Child's Dentist: _____

Dentist's Address: _____

Dentist's Phone: _____

ACADEMY OF ST. ADALBERT EXTENDED DAY PROGRAM

FEE PAYMENT AGREEMENT

Family Name _____

Name of child _____ Grade: _____

Name of child _____ Grade: _____

Name of child _____ Grade: _____

DAYS AND TIMES CHILD/CHILDREN WILL ATTEND PROGRAM

(Please estimate to help us schedule employees.)

Monday: _____ Time: _____

Tuesday: _____ Time: _____

Wednesday: _____ Time: _____

Thursday: _____ Time: _____

Friday: _____ Time: _____

I understand and agree that a one time non-refundable enrollment fee of \$25.00 is to be paid in advance with the completed registration forms. I also understand and agree to pay my child's program fee: \$3.00 an hour for the first child, and \$2.00 an hour for each additional child from the same family. This fee is payable on Monday or the first day my child attends each week. I agree to pay any late fees incurred on the day when a "late pick-up" occurs. I also understand that my account may not be more than two (2) weeks in arrears.

LATE FEE CHARGES: A \$3.00 service charge will be incurred for each fifteen (15) minute increment after 6:00PM that a child is picked up late. This is paid directly to the person who is inconvenienced by the delay.

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

ACADEMY OF ST. ADALBERT EXTENDED DAY PROGRAM

CHILD PICK-UP AUTHORIZATION

Name of child: _____

Approximate pick-up time: _____

The following person(s) have my authorization to pick up my child/children:

Name of adult	Relationship to child	Identification to be used
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Name of adult	Relationship to child	Identification to be used
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Name of adult	Relationship to child	Identification to be used
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The Director will have a sign-out sheet that must be signed by the parent or designated pick-up adult each day prior to the child's dismissal. **The designated pick-up adult MUST show a driver's license or other picture ID before being permitted to pick up any child.**

I understand that the above names are the only persons designated to pick up my child at the Extended Day Program. I also understand that requests made by phone asking that my child be directed to walk home, take a cab, go home with another student, or another person who is not listed above **WILL NOT BE HONORED**. Changes in the ordinary pick up procedure must be sent to the Program Director in writing.

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

ACADEMY OF ST. ADALBERT EXTENDED DAY PROGRAM

MEDICAL EMERGENCY AUTHORIZATION

Insurance Plan Name: _____

Insurance Plan Number: _____

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor _____ Telephone _____

Dentist _____ Telephone _____

Medical Specialist _____ Telephone _____

Hospital _____ Telephone _____

In the event reasonable attempts to contact me at (home phone) _____, (work phone) _____, (cell phone) _____, or (pager) _____ or the other parent/guardian _____ at (home phone) _____, (work phone) _____, (cell phone) _____, or (pager) _____ have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by the above-named doctors, or, in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of my child to the above-named hospital or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____