COMMUNION of SAINTS SCHOOL
FOSTERING FAITH, SERVICE AND SCHOLARSHIP
2160 Stillman Road | Cleveland Heights | Ohio | 44118 | 216.932.4177 | www.communionofsaintsschool.org

AFTER SCHOOL CARE REGISTRATION

The After School Care program provides care for Communion of Saints School children with working parents. The ASCP accepts children in Kindergarten through grade 8. Each day the program offers children a choice of activities, including arts and crafts, games, music, and both indoor and outdoor play. Children can choose whether or not to participate in organized activities or to initiate their own. A homework slot and a snack time are included on the calendar each day.

The ASCP meets **after school from 2:30 p.m. to 6:00 p.m**.

Registration Fee: $25.00 (per family)

Cost of program: $6.00 per hour per child

($10.00 per hour maximum per family)

Parents are responsible for keeping their accounts current.

Late Pick up Fee: $20 charge plus $1.00 for each minute after 6:00 p.m.

Payment Due Date: All fees are billed on a bi-monthly basis

Late Payment Fee: $10.00 per week will be charged for each week the bill remains unpaid.

Please complete:

Fee Payment Agreement Form

Contact Info/ Medical Authorization form

By AUGUST 27, 2018.

After care services will be available on the first day of school for those who have completed the forms and paid the registration fee.

Communion of Saints School
After School Care Program (ASCP)

FEE PAYMENT AGREEMENT

Name of Children: Grade Level (as of August)

_____

_____

_____

Please CIRCLE ONE of the following payment options

REGULAR USE: Write in the pick-up time next to the days your child/ren will attend the ASCP:

Mon._____**Tues:**_____**Wed:**_____**Thurs:**_____**Fri:**_____

CALENDAR: You agree to provide a calendar each month-due the last week of the previous month-with the dates and pick up times for your child/ren.

WILL CALL: You need ASCP on an as-needed or emergency only basis. You agree to contact ASCP by 2:00pm on the day you need your child to attend ASCP.

*I understand that a non-refundable registration fee of $25 per child is to be paid when registering

*I understand that there are no refunds or credits issued for sports, choir, drama, or any other after school activity or meeting conflicting with the contracted time

*I understand the late fee information contained in the Policies and Procedures.

CHILD PICK-UP AUTHORIZATION

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

Name of Adult Relationship to Child Phone

_____

_____

_____

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 students dismissal.

I understand that the above names are the ONLY persons designated to pick up by child. In the event that another is going to pick up my child at any time I will notify the ASCP director **before 2:30pm**.

Signature of Parent:_____**Date:**_____

After School Care Program

CONTACT INFO / EMERGENCY MEDICAL AUTHORIZATION

Family Last Name:_____

Name(s) of Child(ren): 1._____Grade:_____ 2._____Grade:_____

3._____Grade:_____ 4._____Grade:_____

Father's Name:_____Signature:_____

Day Phone:_____Cell Phone:_____

Mother's Name:_____ Signature:_____

Business Phone:_____ Cell Phone:_____

Guardian Name:_____ Signature:_____

Day Phone:_____ Cell Phone:_____

(EITHER PART 1 OR PART 2 MUST BE COMPLETED)

PART 1- TO GRANT CONSENT

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

Physician:_____Phone:_____

Dentist:_____Phone:_____

Medical /Specialist:_____Phone:_____

Local Hospital:_____**Allergies/ Chronic Conditions**_____

Medications currently being administered to child:_____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above named doctor(s), or in the event the designated preferred practitioner is not available, by another licensed physician or dentist: and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of 2 other board certified physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such life-saving surgery.

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

_____

_____

_____

Signature of Parent/ Guardian:_____Date:_____

PART 2- REFUSAL TO CONSENT

I do NOT give consent for emergency treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the ASCP authorities to take the following action:

_____

_____

Signature of Parent/ Guardian_____Date:_____