

SCHOOL AGE CHILD CARE

PARENT FORMS

"2009-2010" School Year



Lake Shore Public Schools School Age Child Care (SACC)

Masonic Heights

Tanya Cummins
Site Supervisor
22100 Masonic Blvd.
St. Clair Shores
(586) 285-8519

Rodgers

Lora Gonzales
Director/Site Supervisor
21601 L'Anse
St. Clair Shores
(586) 285-8618

Violet

Nicole Oliver
Site Supervisor
22020 Violet
St. Clair Shores
(586) 285-8711

School Age Child Care – 2009/2010 – School Year

The **School age Child Care** staff wants things to go as smoothly as possible for you and your child in terms of childcare in the fall. Therefore, it is extremely important for you to let us know if you will be using the SACC programs in the fall. **PLEASE COMPLETE AND RETURN THE ATTACHED FORMS TO YOUR CHILD'S CENTER AS SOON AS POSSIBLE.**

The centers at Masonic Heights, Rodgers and Violet schools are open during the school year from 6:00 A.M. until school starts and from dismissal until 6:00 P.M. The centers are closed for Christmas, Mid-Winter Break, and Easter. Our SACC program also offers a summer camp program which requires a separate enrollment form and fee.

We require a non-refundable Registration Fee of \$35.00 per child for the coming school year. If you are re-registering, this check MUST be separate from your weekly tuition fees check.

A fee of **\$4.18 per hour** is charged. A discount is available for siblings enrolled in the same program. Fees are determined by the number of childcare hours used.



Lake Shore Public Schools
Office of School Age Child Care
21601 L'Anse Avenue
St. Clair Shores, Michigan 48081
(586) 285-8617

Lora Gonzales
Director

Fall 2009

Thank you for your interest in the School Age Child Care program at Lake Shore Public Schools. Enclosed you will find the parent brochure and required forms that need to be completed for registration. Your child will be considered registered and can **begin** attending when the required paperwork is **completed** and turned in to the site supervisor at your child's school along with the registration fee and a prepay tuition payment.

In closing, if you have any questions please feel free to contact the site supervisor at your child's school. Please feel free to contact me by telephone at 586-285-8617, by email lgonzales@lspss.org, or stop by the School Age Child Care office. Again, thank you for your interest in the School Age Child Care program at Lake Shore Public Schools.

Sincerely,
Lora Gonzales
Director of School-age Child Care
Lake Shore Public Schools

S.A.C.C REGISTRATION CHECKLIST

✓ COMPLETED PARENT FORMS

✓ REGISTRATION FEE OF \$35.00 PER CHILD CHECK
MADE PAYABLE TO LAKE SHORE PUBLIC
SCHOOLS

✓ FIRST WEEKS SCHEDULE

✓ ESTIMATED TUITION PAYMENT AT \$4.18 PER
HOUR CHECK MADE PAYABLE TO LAKE SHORE
PUBLIC SCHOOLS

AT THIS TIME, S.A.C.C DOES NOT ACCEPT CREDIT OR
DEBIT CARDS. PLEASE PROVIDE SEPRATE
PAYMENTS FOR THE REGISTRATION FEE AND THE
TUITION.

CERTIFICATE OF GOOD HEALTH

The **State of Michigan**, our licensing agency, requires a current health appraisal form to be on file for each student. We have received an exemption from that rule because we enroll only students from the local school. In its place, we are asking you to complete this form.

Child's Name: _____ Date of Birth _____

| Is your child having any of the problems listed below? | YES | NO |
|---|------------|-----------|
| 1. Allergies or reactions (for example, food, medication, or other) | | |
| 2. Hay Fever, asthma, or wheezing | | |
| 3. Eczema or frequent skin rashes | | |
| 4. Convulsions/Seizures | | |
| 5. Heart Trouble | | |
| 6. Diabetes | | |
| 7. Frequent colds, sore throats, earaches (4 or more per year) | | |
| 8. Trouble passing urine or bowel movements | | |
| 9. Shortness of breath | | |
| 10. Speech problems | | |
| 11. Menstrual problems | | |
| 12. Dental problems: date of last examination | | |
| 13. Other | | |
| Please explain any problem areas identified above: | | |
| | | |
| | | |
| Does your child take any medications regularly? | | |
| If yes, what medication? | | |
| Reason for Medication: | | |

I hereby certify that my child is in good health and that his/her immunizations are current. I will assume responsibility for my child's health while at the childcare center.

Signature of Parent of Guardian: _____ Date: _____

LAKE SHORE – SACC BREAKFAST AGREEMENT:

I understand that the Lake Shore SACC Program does not provide breakfast. This is to verify that, on occasion, I will send ready-to-eat food with my child in the morning that will serve as all or part of his or her breakfast.

Child's Name: _____



Signature of Parent/Guardian: _____

Date: ____/____/____

LUNCH/SNACK AGREEMENT:

I hereby acknowledge that it is my responsibility to provide my child with lunch while he/she is in attendance at the Lake Shore SACC Program.

I understand that snacks will be served each day. A snack list will be posted on the parent board.



Signature of Parent/Guardian: _____

Date: ____/____/____

WALKING FIELD TRIPS:

Children enrolled in the Lake Shore SACC Program on occasion will be going on walking field trips off school grounds but within the school community. My child has permission to participate in the walking trips with the Lake Shore SACC program staff.

Signature of Parent/Guardian: _____



Date: ____/____/____

PG - MOVIE PERMISSION:

On occasion, a carefully selected PG movie will be shown. If you do not object to your child watching PG movies, please sign the form below and return it with the other Parent Forms..

Child's Name: _____ Grade: _____

I understand and give permission for my child to watch carefully selected PG rated movies while in the Lake Shore SACC Program.

Parent/Guardian Signature: _____



Date: ____/____/____

Permission to Photograph Form:

Child's Name: _____

I hereby give my permission for the child named above to be video-taped/ photographed for the purposes of showing Lake Shore School Age Child Care activities.

Signature Parent(s)/Guardian: _____



Date: ____/____/____

LAKE SHORE PUBLIC SCHOOLS SACC PROGRAM

Uniform Parental Medical Consent, Release and Assumption of Risk Form

Student's Name: _____ School Year _____

As used herein: "**FIELD TRIP SPONSORS**", shall include the Lake Shore Public Schools, attending faculty members, adult chaperons and licensees, and "**UNDERSIGNED**" shall be the father and/or mother, or the guardian, or the student if eighteen years or older.

The **UNDERSIGNED** understand that during the field trip in which the student is participating under the direction of the **FIELD TRIP SPONSORS**, certain risks and dangers may occur, including but not limited to hazards of accidents or illness, the forces of nature, and travel by airplane, automobile, bus, train or other conveyance.

In partial consideration of, and as partial payment for, the right to participate in this field trip and related activities and to utilize the services, including food, as provided, the **UNDERSIGNED** hereby assume all the risks set forth above and hereby hold the **FIELD TRIP SPONSORS** harmless from any and all liability, actions, causes of actions, debts, claims, and demands of every kind and nature whatsoever which arise from or in connection with the above described field trip and related activities. The terms hereof shall serve as a release and assumption of risks for the heirs, executors, administrators and members of the student's family.

In the event emergency medical treatment is required for the student while he is under the control and direction of the **FIELD TRIP SPONSORS** and if consent is a requisite to any such treatment, the **UNDERSIGNED** hereby grant to the **FIELD TRIP SPONSORS** the right to give consent to such treatment for the student on the behalf of the **UNDERSIGNED**. Said consent may be granted or withheld by the **FIELD TRIP SPONSORS** as each of them, in their sole discretion, shall determine. The **UNDERSIGNED** hereby waive any claim which they may have against the **FIELD TRIP SPONSORS** arising from the granting or withholding of the aforesaid consent.

Student's Name: _____ Birthdate _____

Parent/Guardian Signature _____

Home Address _____ Zip _____

Home Telephone Number: () _____ Work Telephone Number: () _____

Cell Telephone Number's: () _____ () _____

Health Insurance Company's Name: _____

Identifying Policy Numbers: _____

Insurance Company's Telephone Number: _____

Lake Shore Public Schools - SACC Programs

Emergency and Release Child Information Card

Date of Admission: ____/____/____

Date of Discharge: ____/____/____

Please indicate which site your child attends: Rodgers____ Violet____ Masonic Heights____

May we contact you at work? YES____ NO____ Whom does your child live with? _____

E-Mail Address: _____

| | | | | |
|--|-----------------------------|-------------------------------------|--|----------|
| Name of Child (Last, First, Middle Initial) | | Name of Parent(s)/Guardian(s) | | |
| ALLERGIES, IF ANY | | Child's Address (Number and Street) | | |
| Father's Address (If different) | | Mother's Address (If different) | | |
| Child's Date of Birth | Home Phone Number () | City | State | Zip Code |
| 1. Parent Location when Child in Care Mother | | Hours of Employment | Phone Number and/Cell Number () | |
| Address (Number & Street) | City | State | Zip | |
| 2. Parent Location when Child in Care Father | | Hours of Employment | Phone Number and/Cell Number () | |
| Address (Number & Street) | City | State | Zip | |

PERSON OTHER THAN PARENT TO BE NOTIFIED IN EMERGENCY SITUATION WHEN PARENT IS NOT AVAILABLE

| | | | | |
|----------------------------|------|--|----------|--|
| Name/Relationship to Child | | Phone Number and/Cell Number () | | |
| Address (Number & Street) | City | State | Zip Code | |

NAMES OF PERSONS OTHER THAN PARENT TO WHOM CHILD MAY BE RELEASED-INCLUDE PERSON NAMED ABOVE

| | | | |
|----|--------------|----|--------------|
| 1. | Phone/Cell # | 2. | Phone/Cell # |
| 3. | Phone/Cell # | 4. | Phone/Cell # |

I hereby give permission to **Lake Shore Public Schools-SACC** programs - licensed by the State of Michigan to secure emergency medical and/or emergency surgical treatment for the above-named minor child while in care.

Non-emergency medical treatment or elective surgery is not included in this authorization.

| | | |
|--|-------------|---|
| Signature of Parent or Guardian | Date Signed | Authority: Act 116 of P.A. 1973. COMPLETION: Required. Penalty: Rule Violation Citation |
|--|-------------|---|

Space for Notarization (If Required by Local Medical Facility)

| | | | |
|---|------|--|------------------------|
| Name of Child's Physician or Health Clinic | | Office Hours | Phone Number () |
| Address (Number & Street) | City | State | Zip |
| Hospital Preferred for Emergency Treatment | | Health Insurance Policy Name and Group Number | |