Hilliard City School District

**School-Age Child Care Program Registration 2016-2017**

Office Use: Date \_\_\_\_\_\_\_\_\_\_\_\_

Check #\_\_\_\_\_\_\_\_\_Amount \_\_\_\_\_\_

BK\_\_\_ LR\_\_\_\_ Entered\_\_\_\_

**SACC Site** where you are registering child/ren or the school your child/ren will attend in the fall.

|  |  |  |  |
| --- | --- | --- | --- |
| SCHOOL NAME |  | START DATE: |  |

*If you register for more than one SACC site you must pay 2 registration fees*

**CHILD ONE**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| CHILD FIRST & LAST NAME | AGE | GRADE 16-17 | DATE OF BIRTH | GENDER |

# Please check the square to indicate status

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Full Time A&P |  | Full Time AM |  | Full Time PM |  | Previously enrolled? Yes No |
| 12 Flex A&P |  | Part Time AM |  | Part Time PM |  | Year |

**CHILD TWO**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| CHILD FIRST & LAST NAME | AGE | GRADE 16-17 | DATE OF BIRTH | GENDER |

# Please check the square to indicate status

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Full Time A&P |  | Full Time AM |  | Full Time PM |  | Previously enrolled? Yes No |
| 12 Flex A&P |  | Part Time AM |  | Part Time PM |  | Year |

Child(ren) live(s) with  Both Parents  Mother  Father  Guardian  Shared Parenting

**Primary Contact Secondary Contact**

|  |  |  |  |
| --- | --- | --- | --- |
| First Name |  | First Name |  |
| Last Name |  | Last Name |  |
| Home Phone |  | Home Phone |  |
| Address |  | Address |  |
| City/State/Zip |  | City/State/Zip |  |
| Employer Name |  | Employer Name |  |
| Work Phone |  | Work Phone |  |
| Cell Phone |  | Cell Phone |  |
| Email |  | Email |  |

###### Party responsible for payment Both Primary Contact Secondary Contact

Would you like a monthly receipt mailed to primary contact.  Yes  No

**\*Please complete each blank. Write N/A if items is not applicable**

**Persons authorized to pick up your child other than parents or guardians.**

*To deny a non-custodial parent the authority to pick up your child, copies of the court order must be on file.*

Name Phone Relationship to Child

|  |  |  |  |
| --- | --- | --- | --- |
| 1) |  |  |  |
| 2) |  |  |  |
| 3) |  |  |  |
| 4) |  |  |  |

MEDICAL RELEASE

If medical care is deemed necessary & I cannot be contacted, I authorize the child care staff, trained in first aid, to act on my behalf in providing appropriate care. I understand I am responsible for updating my contact information.

|  |  |
| --- | --- |
|  |  |
| \*AUTHORIZED SIGNATURE | DATE |

**\*Typing your name on this form is your digital signature and gives us authorization to ensure appropriate medical care for your child.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Physician Name** |  | **Phone** |  |
| **Dentist Name** |  | **Phone** |  |
| **Preferred Hospital** |  | | |

**List Any Medical Conditions Requiring Special Attention**

*SACC Program does not have access to the school’s medical records or medication.*

*Place N/A in the fields below if they do not apply.*

|  |  |  |
| --- | --- | --- |
|  | Child’s Name | Child’s Name |
|  |  |  |
| **Allergies** |  |  |
| **Diet Considerations** |  |  |
| **Medications** |  |  |
| **Special considerations in the care of your child/ren** |  |  |
| **Your Child/ren Special Area of Interest** |  |  |

###### Photographic Permission

I do give permission to have my child appear in any media coverage approved by the SACC director. I understand that the Site Coordinator and Program Director has been given authority by the SACC Advisory Board to determine appropriate requests. **Typing your name on this form is your digital signature and gives us authorization photograph your child.**

|  |  |
| --- | --- |
|  |  |
| \*AUTHORIZED SIGNATURE | DATE |