SISD R.D. MARTINEZ ELEMENTARY

AFTER SCHOOL CHILD CARE PROGRAM

Date of Application _____ **Date of Admission _____**

Name _____ Date of Birth _____

Home Campus: R.D.Martinez Elementary Grade _____

Teacher _____

Address _____ Home Phone # _____

_____

Parent's or Guardian's Name _____

Address (only if different) _____

List telephone numbers where parents may be reached while child is in care:

Mother's Work #_____ Father's Work # _____

Mother's cell# _____ Father's cell # _____

Give a name of a person to call in case of an emergency, if Parents/Guardians cannot be reached.

Name	Phone #	Relationship
_____	_____	__ _____
_____ _____	_____	_____
_____ _____	_____	_____
_____	_____	_____

Upon enrollment, I understand the fee is $5.00 per day payable one month in advance on the dates in the payment schedule. **All payments are non-refundable**. There will be a $5.00 per day late charge for any payment made after the due date. No fees will be accepted later than the third day following the payment due date for each respected month. If the fees are not paid by third (3) day, my child will be removed from the program.

Parent Signature _____

- My child has been examined within the past year by a licensed physician and/ or is in good physical health and is able to participate in the SISD After School Child Care Program

  Parent Signature: _____

- I understand the SISD After School Child Care Program hours are **3:30-6:00 pm**. on regular school days 12:30-6:00 pm. on early release days. If I am late picking up my child, I agree to pay $1.00 per minute for each minute after 6:00 pm.

  Parents Initials _____

- I understand and agree that good behavior is expected of all children in the program. If my child does not follow the rules and/ or instructions while in the program, he/she will be dismissed from the program and no fees will be refunded.

  Parents Initials _____

- I understand there will be no After School Care on Teacher Staff Development/ Workdays or during Student Holidays. After School Care will be provided on SISD Early Release Days. See attached calendar.

  Parents Initials _____

I agree to personally pick up my child at the **R.D. MARTINEZ AFTER SCHOOL CHILD CARE PROGRAM ROOM** each day. If I cannot, I hereby authorize the **MARTINEZ ELEMENTARY AFTER SCHOOL CHILD CARE PROGRAM** to allow my child to leave the facility with the following persons.

Name/Relationship	Phone #'s
_____	_____
_____	_____
_____	_____

AUTHORIZATION FOR EMERGENCY

MEDICAL ATTENTION

In the event that I cannot be reached to make arrangements for emergency medical attention I authorize the facility director or person in charge to take my child to:

NAME OF HOSPITAL	ADDRESS	PHONE #
_____	_____	_____
NAME OF PHYSICIAN	ADDRESS	PHONE #
_____	_____	_____

I give consent for this facility to secure any and all-necessary emergency medical care for my child.

Signature of Parent of Legal Guardian _____

I understand that the SISD after School Child Care Program does not provide medical insurance. If my child needs medical attention, my personal insurance or I will be financially responsible.

Parents Initials _____ **Date** _____

List any special problems that your child may have such as allergies, existing illness, previous serious illness, and injuries during the past 12 months. Any medication prescribed for long-term continuous use and any other information which staff should be aware of.