St Vincent de Paul School

Print Child's Last Name:
Office Use Only:

SCHOOL AGE CHILD CARE PROGRAM (SACCP)
REGISTRATION FORM 2018-2019

Child's Name _____
(First) (Last)

Mailing Address _____

_____
(City) (Zip)

Home Phone _____

Date of Birth _____ Male/Female Grade _____

Email Address: _____
(This email is used for billing purposes and Extended Care communication only.)

Father/Guardian's Name _____

Address _____

Home Phone _____ Cell Phone _____

Place of Employment _____Work Phone _____

Mother/Guardian's Name _____

Address_____

Home Phone _____ Cell Phone _____

Place of Employment _____Work Phone _____

SACCP Rates (Payment is required on a bi-weekly basis)

AM SACCP 7:00-7:30AM	M-F	$4/day, or $15/week
2:30 PM-4:00PM (K-8)	M-F	$8/day
2:30 PM-6:00PM (K-8)	M-F	$13/day or $50/week

A registration fee of $25, required per family, must accompany this registration form.

Please contact the school office for additional information if needed or you may email amayvill@cdeducation.org.

_____ _____
Parent/Guardian Signature Date

By signing the below I am stating that I have read the contents of the SACCP/PSEC handbook online on the School Speaks STV website and understand that my child(ren) and I will follow the policies that were set according to the St. Vincent de Paul School SACCP/PSEC Handbook for the 2018-2019 school year.

_____ _____
Parent/Guardian Signature Date

DOUBLE SIDED FORM – PLEASE TURN OVER

Student Name (Last, First) _____

In the event this student becomes ill at school but does not need medical attention, name three people, i.e. relative, neighbor, childcare provider, to be contacted if you cannot be reached.

1._____ Relationship:_____ Phone: _____
2._____ Relationship:_____ Phone: _____
3._____ Relationship:_____ Phone: _____

Please list any other persons that you will allow to pick up your child from Extended Care. Remember they must be on this list to pick up your child. We take this extremely seriously and require a signature upon your child's pick up.

_____ Relationship:_____ Phone: _____
_____ Relationship:_____ Phone: _____
_____ Relationship:_____ Phone: _____
_____ Relationship:_____ Phone: _____

_____ _____
Parent/Guardian Signature Date

Please give any pertinent information regarding the health of this child: _____
_____
_____

Emergency Medical Authorization (State of Ohio Revised Code Section 3313.712)

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority when parents or guardians can not be reached.

PART I or PART II MUST BE COMPLETED

PART I: TO GRANT CONSENT

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

Physician: _____ Phone: _____
Dentist: _____ Phone: _____
Medical Specialist:_____ Phone:_____
Local Hospital:_____ Emergency Room Phone:_____

In the event reasonable attempts to contact me have been unsuccessful, I herby give my consent for (1) the administration or any treatment deemed necessary by above named doctors, or, in the event the designated preferred practitioner is not available by another licensed physician, 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 two other licensed physicians or dentists concurring on the necessityfor 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: _____
_____
_____
_____

Date: _____ Signature: _____

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

PART II: REFUSAL TO CONSENT

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

Date: _____ Signature: _____ **DOUBLE SIDED FORM – PLEASE TURN OVER**