CHSAP 2017 – 2018 Registration Form (OFFICE USE ONLY)

Registration No.__________ Date Received___________ Time _______

Registration Paid? Y or N Check #___________

110 E. Upland Road, Ithaca, NY 14850
Phone: 607-257-0368
Website: www.cayugaheightsafterschool.org
Email forms to: information@cayugaheighsafterschool.org

Submission Instructions: When turning in your form, please send the form attached to a new email with the following subject line: REGISTRATION 2017-2018 (YOUR CHILD'S NAME). **Do not hit reply to this email!** This ensures that your child's registration form will be properly received and time stamped.

2017-2018 Registration Form

Please complete a separate form for each child

Child's Name ________________________________ Age _________ Date of Birth ____________ Sex M / F

Grade in 2016-2017_____________Bus to CHSAP? Y / N

Home Address____
Street and Number City State Zip

Parent/Guardian_____________________ Home #____________________ Work #_____________________
Cell #_______________ E-mail Address ________________________

Parent/Guardian_____________________ Home #____________________ Work #_____________________
Cell #_______________ E-mail Address ________________________

What is the best way to contact you during CHSAP hours? Please circle: Home phone / Work phone / Cell phone

When CHSAP goes on a field trip, your child will be transported either by ICSD bus or TCAT bus.

Billing E-mail Address (this is where we will e-mail your bill each month): _________________________

*****WHEN PAYING, PLEASE WRITE YOUR CHILD'S NAME IN THE MEMO SPACE OF YOUR CHECK*****

Emergency contacts (if parents/guardians are not available — MUST BE COMPLETED)

Name____ Relationship: ________________________________
Home#____________________ Work#____________________ Cell#_____________________________

Name____ Relationship: ________________________________
Home#____________________ Work#____________________ Cell#_____________________________

Individuals authorized to pick up this child (other than parents/guardians)

Name___________________ Home#_____________ Work#_____________ Cell#___________

Name___________________ Home#_____________ Work#_____________ Cell#___________

Name___________________ Home#_____________ Work#_____________ Cell#___________

Name___________________ Home#_____________ Work#_____________ Cell#___________

CHSAP Financial Agreement

Child's Name: ____

I acknowledge and agree to pay the following fees (**which are subject to change at any time**):

Step 1: ***Circle day(s) of care needed and initial.***

Monday	Tuesday	Wednesday	Thursday	Friday

Initial: ______

Step 2: ***Circle and initial your rate of pay based on the number of day(s) your child will be attending CHSAP.***

Number of Days per Week	Monthly Tuition*	Monthly Sibling Tuition *
5	$300.00	$270.00

Initial:_____

***Fees subject to annual increase.**

Step 3: ***Please read and check the box to the following clauses and sign below.***

I understand that:

- ❑ There is a $30 registration fee per child. In order to secure you child's spot, this fee must be paid by check the CHSAP office within the same week of whatever registration wave you submit your child's form. Please see current enrollment letter to confirm dates.
- ❑ The payment system is based on a flat fee paid on a monthly basis.
- ❑ I will receive a bill at the beginning of each month.. Payment is due on the 15th of each month. A late fee will be assessed on any balance that is more than 30 days past due.
- ❑ If my child attends CHSAP for any number of days in a given semester, I am responsible for a full semester's tuition that semester. There will be no refund or reimbursement for absences on regularly scheduled afterschool days.
- ❑ Full day care is available for days when the school is closed, including selected holidays. Fees for these days are included in my child's tuition.
- ❑ Any changes to my child's regular afterschool schedule between semesters require a minimum advanced notice of one month (30 calendar days).
- ❑ If I choose to withdraw my child from the program, I must provide at least one month's (30 calendar days) advance notice.
- ❑ I understand that by signing this registration form, I am taking full fiscal responsibility for all charges associated with my child's account, as determined by the Cayuga Heights School Age Program.
- ❑ I understand that if I receive funds from the NYS Division of Family Services, I am responsible for any co-pay the state deems that I am responsible for. In addition, I am responsible for paying any remainder of my childcare fees that state funds do not cover.
- ❑ If for any reason the state denies payment for charges accrued on my child's account, I understand that I am responsible for paying them.
- ❑ I understand that if my account is delinquent for 30 days or more, that childcare services for my child will be terminated, unless payment arrangement has been reached at the CHSAP director's discretion. Once my account is paid in full, my child's name will be placed on the bottom of the waitlist.

- ❑ Children eligible for reduced or free lunch may receive a reduced tuition fee. Please contact the director for more information.
- ❑ It is my responsibility to keep my child’s medical requirements current to comply with New York State regulations.

Parent/Guardian Signature: __________________________________ Date: ________________

Medical Information

Child's Name: ____

I understand that the program will attempt to contact parents/guardians immediately in case of sickness or accident affecting their child. In the event I cannot be reached or immediate medical attention is required, I authorize the Cayuga Heights School Age Program to seek medical attention as necessary. I further understand that I am financially responsible and that my insurance company will be billed first.

I give permission for the attending physician to give emergency treatment—including anesthesia, injections, and X-rays as necessary on arrival—only if my child's own physician is unavailable at that time to oversee medical treatment of my child.

I verify that my physician has examined my child and determined that he/she is physically fit and all immunizations are up to date.

Please list any allergies or medical conditions for your child:

Please list anything else of interest for your child (e.g., vegetarian, non-swimmer):

Physician: ______________________________ Phone #:______________________________

Dentist: ______________________________ Phone #:______________________________

IN THE EVENT OF AN EMERGENCY CHSAP WILL CALL AN AMBULANCE FOR YOUR CHILD

PERMISSION STATEMENT

- ❑ I give permission for my child to participate in field trips on foot.
- ❑ I give permission for my child to participate in field trips by bus.
- ❑ I give permission for CHSAP to take photos of my child and use them in newsletters, brochures, and other marketing materials.

Parent/Guardian Signature: ____________________________________ Date: ____________