CARES APPLICATION FORM
2024-2025 SCHOOL YEAR

LAST NAME: _____

FIRST NAME: _____ GRADE: _____

FIRST NAME: _____ GRADE: _____

FIRST NAME: _____ GRADE: _____

ADDRESS: _____

_____

HOME PHONE: _____

FATHER'S NAME: _____ CELL #: _____

MOTHER'S NAME: _____ CELL #: _____

ADDITIONAL PARENT PHONE NUMBERS WHERE YOU CAN BE REACHED DURING CARES HOURS:

1). _____ 2). _____

COST FOR PROGRAM: $15.00/PER HOUR FOR ONE CHILD $17.00/PER HOUR TWO OR MORE CHILDREN

PLEASE CHECK THE PROGRAM YOU WILL BE USING:

_____ AM CARES 7:00 – 8:00 _____ PM CARES 2:30-6:00 _____ K-8 PM CARES 3:00 – 6:00

STUDENT EMERGENCY INFORMATION:

Child's Name: _____ Child's Name: _____

Allergies: _____ Allergies: _____

HOMEWORK OPTION: - PLEASE CHECK ONE

Homework completed at CARES _____
Homework completed at home _____

My child/children may be released to the above listed emergency contacts. _____Yes _____ No

My child/children have permission to walk to Merwood Park during CARES. _____ Yes _____ No

MEDICAL INFORMATION

My child has the following medication condition/s that all staff should be aware of in the event of an incident:

_____

_____

SNOW EMERGENCY CLOSING INFORMATION

If school is closed, there will be NO CARES.
If school is dismissed early, parents will be notified of operational hours for the remainder of the day.
If there is a two hour delay, there will be NO AM CARES.

My signature indicates that I have read and understand the CARES Handbook and give approval, as noted, for the cares of my child/children.

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

REGISTRATION FEE: $25.00/ONE CHID $35.00/TWO OR MORE CHILDREN
*Your child will not be guaranteed a spot in CARES if this form is not received by 6/30/2023.

Options for Payment
Authorization to take registration fee out of my FACTS account (**if on the monthly option plan in FACTS**)

_____ Amount: _____
Signature

Venmo: @Cardinal John Foley-school _____ Please submit by 5.15.24

Check enclosed: _____

*With FACTS or Venmo option application form can be emailed to: dleonard@cjfschool.org

DUE TO THE REGULATIONS OF THE STARS PROGRAM, TWO ADDITIONAL FORM ARE REQUIRED.

Emergency Contact/Parental Consent Form - must be completed for each child that is registering for CARES.

- Every section must be completed in its entirety. If a particular box does not pertain to your child, you must write N/A.
- Please note your signature is required in four places on the bottom of the form – the three starred boxes and the first signature line.
- You will be asked to review and/or update this form every six months and an additional signature on the second line will be needed at that time.

Child Health Report

This form must be from your child's most recent well visit. If your child's well-visit is scheduled between now and September, you may wait to turn in this form at a later date, but please note that your child/children will not be able to attend the CARES program without this form completed by your physician.

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.

EMERGENCY CONTACT / PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124 (a) (b), 3270.181 & 182; 3280.124 (a) (b), 3280.181 & .182; 3290.124 (a) (b), 3290.181 & .182

CHILD'S NAME	DATE OF BIRTH
ADDRESS	
PARENT'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER ( )
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	
PARENT'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	

EMERGENCY CONTACT PERSON(S) NAME	TELEPHONE NUMBER WHEN CHILD IS IN CARE

PERSON(S) TO WHOM CHILD MAY BE RELEASED NAME	ADDRESS	TELEPHONE NUMBER WHEN CHILD IS IN CARE

NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER	TELEPHONE NUMBER
ADDRESS	

SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTION)
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICATION, SPECIAL SITUATION
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD	
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS	POLICY NUMBER (REQUIRED)

PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT

* **OBTAINING EMERGENCY MEDICAL CARE** ***	***ADMIN. OF MINOR FIRST-AID PROCEDURES** ***
WALKS AND TRIPS ****	SWIMMING N/A
TRANSPORTATION BY THE FACILITY N/A	WADING N/A

PERIODIC REVIEW

*Sign and date now

SIGNATURE OF PARENT or GUARDIAN _____ DATE _____

*Sign and date later

SIGNATURE OF PARENT or GUARDIAN _____ DATE _____

WHITE COPY (Original) **YELLOW COPY** (Child Care Space) **PINK COPY** (Excursion)