ST. AUGUSTINE
CATHEDRAL SCHOOL

St. Augustine Cathedral School After School Program

Registration Form

Name of child	Birth date	Grade
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Days/Hours of Operation
The After School Care Program follows the school year calendar. The program operates on full days only. **ASC closes at 6:00pm.** Any parent picking up a student after that time will be charged $5.00 for **EVERY MINUTE PAST THE CLOSING HOUR**. The director may use discretion for extenuating circumstances.

Fee Policy and Payment
$3.00/hr. per child
After School Care payments are due on by the 15th of each month. Parents are notified by email that ASC charges/balances are available to view in FACTS. To view your balance, log into your FACTS Family Portal, family, family billing, childcare. You can also click "details" for more information. If you have any Questions about your balance, or if you are unable to view your balance, please contact the school office.
To make a payment, please go the payment portal on our school website or drop a check off in the school office. **Accounts must be paid in Full by the 15th. Failure to do so will result in a $10.00 late fee. Failure to pay for 2 consecutive months will result in dismissal from the program.**

Signature of Parent, Legal Guardian, Responsible Adult — Date

Printed Name — Relationship to Child

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Physical Health Form

R 400.5305(1)

My child, _____, is in good health.

My child, _____, has the following health concerns and/or restrictions:

_____

_____

My child, _____:

_____ is up to date on his or her immunizations and a record is on file with St. Augustine Cathedral School.

_____ has a waiver from the County Health Department on file with the school.

_____ _____

Parent signature

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Parental Agreements:

- I have received and read the St. Augustine After School Care Program parent handbook and agree to follow the policies and procedures therein.
- I understand that this program will be operated is a similar manner to the rules and expectations of the expectations of the school, in areas of language, behavior, and acceptable activities.
- I understand that I am responsible for providing appropriate and healthy snack for my child each day he/she is in attendance. I understand that all snacks need to be labeled with the child's first name and date that snack is to be eaten.

_____

Print your name

_____ _____

Signature Date

CHILD INFORMATION RECORD

State of Michigan - Department of Licensing and Regulatory Affairs - Child Care Licensing

Instructions: Unless otherwise indicated, all requested information must be provided. If the information is not known or does not apply, "unknown" or "none" is the required response. A blank field, a line through a field or "N/A" are not acceptable responses.

For Provider Use Only:	Date of Admission	Date of Discharge

Name of Child (Last, First, Middle Initial)				Child's Date of Birth
Address (Number and Street, Building/Apartment Number)		City	State	Zip Code
Parent/Legal Guardian's Name	Home Phone ( )	Parent/Legal Guardian's Name (Optional)		Home Phone ( )
Home Address (if not child's address)	Cell Phone ( )	Home Address (if not child's address)		Cell Phone ( )
City / State / Zip Code		City	State	Zip Code
Email Address (optional)		Email Address		
Employer Name	Work Phone ( )	Employer Name		Work Phone ( )
Name of Child's Physician or Health Clinic		Physician's or Health Clinic's Phone Number ( )		
Hospital Preferred for Emergency Treatment (optional)				
Allergies, Special Needs and Special Instructions (Attach additional sheets, if necessary.)				

BCAL-3731 (Rev. 7-18) Previous edition 6-17 may be used.

See Reverse Side

Emergency Contact & Release of Child: List all individuals, including parents/legal guardians, in order of preference, to be contacted in an emergency. If possible, include at least one person other than the parents/legal guardians to be contacted in an emergency and to whom the child can be released. The second phone number column can be left blank. (If more individuals, attach additional sheets.)

1.	( )	( )
2.	( )	( )
3.	( )	( )

Release of Child Only: List all individuals, other than the parents/legal guardians, to whom the child may be released. (If more individuals, attach additional sheets.)

1.	( )	**2.**	( )
3.	( )	**4.**	( )

Parent/Legal Guardian Initials:

_____I give permission to _____, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical treatment for the above named minor child while in care.

I certify that I accurately completed this form and if anything changes, I will notify the provider by updating this form.

Signature of Parent or Guardian — Date Signed

Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials

LARA is an equal opportunity employer/program.

AUTHORITY: 1973 PA 116
COMPLETION: Required
PENALTY: Rule Violation Citation.

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