

**GREEN TOWNSHIP SCHOOL DISTRICT
CHILD CARE REGISTRATION**

(A \$25.00 per child non-refundable registration fee must accompany registration)

GENERAL INFORMATION:

Child's Name: _____ Date of Birth: _____
Parent's Name: _____ Phone: _____
Mailing Address: _____ Grade/Teacher: _____
City, Zip Code _____ Email address _____

EMERGENCY INFORMATION:

Father's Employer: _____ Phone: _____
Cell: _____
Mother's Employer: _____ Phone: _____
Cell: _____
*Emergency Contact #1 _____ Phone: _____
Cell: _____
*Emergency Contact #2 _____ Phone: _____
Cell: _____

*Should be an adult living locally who can assume responsibility for your child/children.

Please check which of the following program(s) you are requesting. **There are 180 days of school regardless of days off throughout the school year. Note the annual cost may be divided into 10 payments or paid ahead or in full at any time.**

- a. _____ Full-Time (1st Child): \$252.40/month, \$2,524.00 annual cost.
Full-Time (2nd Child): \$226.60/month, \$2,266.00 annual cost
Annual total for 2 full time students \$4,790.00
- b. _____ Part-Time (1st Child): \$190.60/month, \$1,906.00 annual cost
Part-Time (2nd Child): \$170.00/month, \$1,700.00 annual cost
Annual total for 2 part time students = \$3,606.00
- c. _____ Drop- In \$17.50 per hour. **This rate applies to occasional attendance. Students regularly attending 2 or 3 days per week will be charged the part time rate.**

SIGNATURES: I hereby understand agree to the fees and regulations attached to this registration form and presented in our Child Care Manual (copy available on line or upon request.)

Parent/Guardian

Date

**GREEN TOWNSHIP SCHOOL DISTRICT
CHILD CARE PROGRAM**

HEALTH HISTORY

Student Name: _____

Grade: _____

DOB: _____

Please provide as much information in this section as possible.

Present Medical Problems: _____

Special care required: _____

Any known **Allergies**: _____

Asthma: _____

Medicine taken regularly: _____

Chronic or Recurring Illnesses: _____

Epi-Pen and Inhalers must be provided by the Parent/Guardian.

Has your Doctor certified that your child can self-administer his/her inhaler and/or Epi-Pen?

Yes: _____ No: _____

A nurse is not available for the AfterCare program.

The Child Care Staff will NOT administer medications, including over the counter medications.

Family Physician: _____

Phone: _____

Parent/Guardian

Date