



## Glassboro Child Development Centers

### Camp HORIZON & JURASSIC Summer Learning Program - 2024 Registration

Child's Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Grade for 2023-2024 School Year: \_\_\_\_\_ Gender: M F **Shirt Size: Youth: S M L XL**

Parent's Name: \_\_\_\_\_ **Adult: S M L XL**

Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

**Does your child require any medication/special accommodations or have any allergies?** \_\_\_\_\_ Yes \_\_\_\_\_ No

**Does your child have an IEP/504 Plan?** \_\_\_\_\_ Yes \_\_\_\_\_ No

*(If yes, must be received and accommodations in place before child begins)*

**Is there a court order (custody or restraining order) involving this child?** \_\_\_\_\_ Yes \_\_\_\_\_ No

*(If yes, we must have a copy, complete with judge/clerk's signature and date)*

**Registration Fees:** \$175 per child  
 Registration fees are non-refundable \_\_\_\_\_ (initial here)

**Pricing:**

Grade	21CCLC only (7am-11am)	In-District (11am-5:30pm 3 <sup>rd</sup> -8 <sup>th</sup> grade)	Out-of-District (7am-5:30pm)
1	n/a	Full day \$160	\$250
2	n/a	Full day \$160	\$250
3	Free	\$80	\$250
4	Free	\$80	\$250
5	Free	\$80	\$250
6	Free	\$60	\$195
7	Free	\$60	\$195
8	Free	\$60	\$195

**\*\*Students attending the 21CCLC portion of the day only who are not picked up by 11am will be assessed a \$16 fee due upon pick-up. Students will not be able to attend the next day without payment.\*\***

*We accept NJCK Voucher/WFNJ  
 United in Care Tuition Assistance Available  
 There is no 2<sup>nd</sup> child discount.*

- **MUST pay for the weeks registered whether they attend or not.**
- Breakfast & PM snack are provided daily.
- Must pack a totally disposable lunch.
- Registration fee and first week are due at time of enrollment.

**All families are required to have an active ProCare account.**

Fees are **automatically** deducted every week.



## EMERGENCY AND RELEASE INFORMATION

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

SITE: \_\_\_\_\_

### **Parent 1 Contact Information**

Name: \_\_\_\_\_

Address (if different): \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_

### **Parent 2 Contact Information**

Name: \_\_\_\_\_

Address (if different): \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_

**Is there a court order (custody or restraining order) involving this child?**

Yes  No

*(If yes, we must have a copy, complete with judge/clerk's signature and date)*

### **PARENTS WILL BE CALLED FIRST IN CASE OF EMERGENCY!**

**IF PARENTS ARE NOT AVAILABLE, THE PERSONS LISTED BELOW WILL BE CONTACTED IN THE ORDER THEY ARE LISTED. PLEASE NOTE: ONLY THE PERSONS LISTED ON THIS FORM ARE AUTHORIZED TO PICK UP YOUR CHILD.**

#### **Authorized Pick-Up #1**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

#### **Authorized Pick-Up #2**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

#### **Authorized Pick-Up #3**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

#### **Authorized Pick-Up #4**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

#### **Authorized Pick-Up #5**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

#### **Authorized Pick-Up #6**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

## EMERGENCY MEDICAL CARE

*This confidential health record will only be used to ensure the safety of the children in this program. This information will not be shared outside of this Childcare program. Feel free to continue your notes on an attached separate sheet.*

1. If my child requires emergency medical care and I cannot be reached, I give my consent to Glassboro Child Development Centers to obtain the necessary medical care for my child. I agree to pay all of the costs associated with the emergency medical care that my child receives. I understand that every effort will be made to contact me before and after medical care is provided.
2. This information is strictly confidential and will not be shared with anyone without my written consent or in the case of emergency medical care.

Student's Doctor: _____	Insurance Company: _____
Phone: _____	Policy Holder's ID: _____
Last Tetanus: _____	Child's Social Security #: _____
Allergies: _____	<b>Religious Preference:</b> (optional) _____
Doctor's Address _____	_____

**Please provide your child's medical history.**

CONDITION	YES	NO
Asthma		
Does your child use an inhaler?		
Convulsions/Seizures		
Diabetes		
Ear Infections		
Chicken Pox		
Measles		
German Measles		
Rheumatic Fever		
Mumps		
Corrective Device (glasses, hearing aid, etc.)		
Any significant illnesses or surgeries?		
**If "yes" to any of the above, please provide the date or any further details.		

ALLERGY	YES	NO
Penicillin		
Insect Stings		
Foods		
Plants		
Hay Fever		
Topical ointments		
Other		
**If "yes" to any of the above, please describe reaction.		
Does your child have an EpiPen®?		

<b>Special situations or needs that staff should be aware of:</b>
<input type="checkbox"/> Child has behavioral /emotional difficulties
<input type="checkbox"/> Child has physical disabilities
<input type="checkbox"/> Child has IFSP, IEP, or 504 Plan.
*We must receive this prior to first day of attendance.

**Special Health Care Needs**

\*\*If yes, the following forms are **required** prior to first date of attendance: the Administration of Medication, Food Allergy Action Plan, or Asthma Action Plan as needed. Medical forms are available for pick up at our main office and must be completed and signed by a health care physician.

I understand that this consent will be in effect as of the date of my signing and will continue as long as my child is enrolled in GCDC programs.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

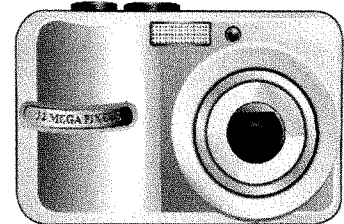


# Glassboro Child Development Centers

## Photo Release Form

Please select site:

- Preschool
- RASKEL@Rodgers
- Horizon @Bullock-Grades 1-2
- JURASSIC@Bullock-Grades 3-5
- JURASSIC@Bowe-Grades 6-8



I, \_\_\_\_\_, hereby \_\_\_ consent/ \_\_\_ do not consent to and authorize Glassboro Child Development Centers the right to use the name of, photograph or likeness of, and statements made by \_\_\_\_\_ (child's name), a minor, in support of the commercial and noncommercial activities, including fundraising operations, videos and social media.

The undersigned acknowledge that no compensation or payment shall be made by the Glassboro Child Development Centers in return for this consent or authorization on the use publication of name, the photograph or likeness of video films or statements of this minor.

This release shall remain in continuous effect until withdrawn in writing by the undersigned.

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian's Name (print): \_\_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_ Witness: \_\_\_\_\_

# PARENT HANDBOOK /POLICY RECEIPT ACKNOWLEDGEMENT

Dear Parent:

In keeping with New Jersey's child care center-licensing requirements we are obligated to provide you, as the parent of a child enrolled at our center, with this statement as well as other policies attached.

Please read the policies and if you have any questions, feel free to contact us at 856-881-3331.

Sincerely,

Joan E. Dillon, Executive Director

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## Please complete and return this portion to the center. (Please print)

I, \_\_\_\_\_, have received the following policies for Glassboro Child Development Centers, outlined in the parent handbook for my child's program:

- |   |   |
|---|---|
| <input type="checkbox"/> Administration of Medication                       | <input type="checkbox"/> Attendance ( <i>Preschool Only</i> )         |
| <input type="checkbox"/> Breastfeeding ( <i>Preschool Only</i> )            | <input type="checkbox"/> Discipline/Expulsion                         |
| <input type="checkbox"/> Communicable Diseases                              | <input type="checkbox"/> Communication/Notification                   |
| <input type="checkbox"/> Completion of Assessment ( <i>Preschool Only</i> ) | <input type="checkbox"/> Dental Health ( <i>Preschool Only</i> )      |
| <input type="checkbox"/> Diapering ( <i>Preschool Only</i> )                | <input type="checkbox"/> Family Engagement                            |
| <input type="checkbox"/> Fee Policies                                       | <input type="checkbox"/> Transportation                               |
| <input type="checkbox"/> Hand Washing Guidelines                            | <input type="checkbox"/> Inaccessibility to Toxic Substances          |
| <input type="checkbox"/> Information to Parents                             | <input type="checkbox"/> Late Pick Up                                 |
| <input type="checkbox"/> Nutrition and Physical Activity                    | <input type="checkbox"/> Parent/Family Code of Conduct                |
| <input type="checkbox"/> Parent Grievance                                   | <input type="checkbox"/> Release of Children                          |
| <input type="checkbox"/> Right to Refuse Services                           | <input type="checkbox"/> Safe Sleep ( <i>Preschool Only</i> )         |
| <input type="checkbox"/> Screen Time  | <input type="checkbox"/> Screening/Referral ( <i>Preschool Only</i> ) |
| <input type="checkbox"/> Supervision of Children                            | <input type="checkbox"/> Transition ( <i>Preschool Only</i> )         |
| <input type="checkbox"/> Toilet Training ( <i>Preschool Only</i> )          | <input type="checkbox"/> Use of Technology and Social Media           |

I agree to abide by the above policies AND other procedures contained in the parent handbook.

\_\_\_\_\_  
Parent/Guardian signature

Names of child/children:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agency Witness

**\*\* THIS PAGE MUST BE RETURNED BEFORE YOUR CHILD ENTERS OUR PROGRAM.**



## BLANKET PERMISSION SLIP

Note: A specific Permission Slip will be given to you for every trip. In the event that we have not received a completed form, or your child was absent at the time the forms were distributed, this Blanket Permission Slip Form will be used along with your verbal permission.

When signed below, this form allows your child to participate in the following activities and services offered by Glassboro Child Development Centers:

- Supervised activities at the center
- Supervised walks around the neighborhood
- Emergency treatment by a physician or dentist in their office or at a hospital (as determined by qualified personnel or the EMT in Glassboro).

Permission is given for all the activities and services specified above by signing this form. My child is in good health and can participate in the normal activities of the GCDC programs. Furthermore, any conditions or special needs that may require special accommodations are described below.

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Child's Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Date: \_\_\_\_\_



## Glassboro Child Development Centers

### INDIVIDUAL PERMISSION FOR TOPICAL OINTMENT & CREAM ADMINISTRATION

Name of Child: \_\_\_\_\_

DOB: \_\_\_\_\_

Type of non-prescribed ointment to be administered:

- Sunscreen
- Diaper Rash
- Bug Repellant
- Other: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

(My signature indicates I understand I must apply the first application of the morning prior to drop off)

\*Being mindful of our students with asthma and allergies, we do **not** permit spray or aerosol cans to be sent in.

\*Special Notes: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date: \_\_\_\_\_

Program/Site: \_\_\_\_\_

Amount to be administered: \_\_\_\_\_

Times to be administered: \_\_\_\_\_

Dates to be administered: \_\_\_\_\_

Location to be administered to: \_\_\_\_\_

My child is under the age of 10 years and requires a staff member to apply the topical ointment, while wearing gloves.

My child is 10 years old or above and can apply their own topical ointment.

I authorize the administration of ointment for my child, \_\_\_\_\_, to receive the above-mentioned ointment according to the directions. I confirm that I have applied at least one application of this ointment without any evidence of side effects or adverse reactions. I understand that it is my responsibility to provide the ointment in its original container, that has been labeled with my child's full name. I UNDERSTAND I MUST APPLY THE FIRST APPLICATION OF THE DAY, PRIOR TO DROP OFF AT GCDC PROGRAMS. I authorize the Director or designated GCDC Staff to apply the above-mentioned ointment.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

#### FOR CENTER USE:

- Is all the above information complete?
- Has the ointment been made inaccessible to children?
- Is the ointment in the original container?

## 2024 NEW JERSEY CHILD AND ADULT CARE FOOD PROGRAM ELIGIBILITY APPLICATION

<b>NAME(S) &amp; AGE(S) OF ENROLLED PARTICIPANT(S)</b>			
	(Name)	(Age)	(Name) (Age)
<i>OPTIONAL: RACIAL/ETHNIC IDENTITY OF PARTICIPANT</i>			
Check one <b>ETHNIC</b> Identity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		Mark one or more <b>RACIAL</b> Identity (ies): <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White	
<b>Enrollment Information</b>			
Check ( ) each day the above participant is enrolled for care, the hours of care each day, and the meal type(s) served:			
DAYS OF CARE: <input type="checkbox"/> MON <input type="checkbox"/> TUES <input type="checkbox"/> WED <input type="checkbox"/> THURS <input type="checkbox"/> FRI <input type="checkbox"/> SAT <input type="checkbox"/> SUN			
HOURS OF CARE: Swing / Rotating Shifts: (If Applicable)    ___:___ - ___:___    ___:___ - ___:___    ___:___ - ___:___    ___:___ - ___:___    ___:___ - ___:___    ___:___ - ___:___			
MEAL TYPES SERVED: <input type="checkbox"/> BREAKFAST <input type="checkbox"/> A.M. SUPPLEMENT <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SUPPLEMENT <input type="checkbox"/> DINNER			

<b>CHILD DAY CARE FOOD PROGRAM PARTICIPANTS ONLY</b>
<b>OPTION 1A: BENEFICIARIES of Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR)</b> If you are now receiving SNAP, TANF or FDPIR for this child, complete <u>one</u> of the following numbers: SNAP CASE # _____ OR    TANF CASE # _____ OR    FDPIR CASE # _____
<b>OPTION 1B: FOSTER CHILD</b> If you are applying for a foster child, check the box and list any personal income which has been identified by specific category such as clothing, school fees, allowances, etc.: FOSTER CHILD    INCOME \$ _____

<b>ADULT DAY CARE FOOD PROGRAM PARTICIPANTS ONLY</b>
<b>OPTION 2: BENEFICIARIES of SNAP, FDPIR, SSI or Medicaid</b> If you are now receiving SNAP, SSI, FDPIR or Medicaid complete <u>one</u> of the following numbers: SNAP # _____ OR    FDPIR CASE # _____ OR    SSI CASE # _____ OR    MEDICAID CASE # _____

<b>OPTION 3: HOUSEHOLD ELIGIBILITY - COMPLETE IF YOU DID NOT COMPLETE OPTION 1A, OPTION 1B, OR OPTION 2</b>					
Complete the following information: Household Members, Social Security Numbers and Income.					
NAMES OF ALL OTHER HOUSEHOLD MEMBERS: <i>(Related and Unrelated)</i>	<b>MONTHLY INCOME (Complete One Or More - Before Deductions)</b>				
	Monthly (Gross Earnings) Wages/Salary	MONTHLY SOCIAL SECURITY PENSIONS RETIREMENT	MONTHLY UNEMPLOYMENT WORKER'S COMPENSATION	MONTHLY WELFARE CHILD SUPPORT ALIMONY	Monthly Any Others Income
1.	\$	\$	\$	\$	\$
2.	\$	\$	\$	\$	\$
3.	\$	\$	\$	\$	\$
4.	\$	\$	\$	\$	\$
5.	\$	\$	\$	\$	\$
6.	\$	\$	\$	\$	\$
7.	\$	\$	\$	\$	\$
8.	\$	\$	\$	\$	\$
9.	\$	\$	\$	\$	\$
10.	\$	\$	\$	\$	\$
<b>TOTAL NUMBER IN HOUSEHOLD (INCLUDE ENROLLED PARTICIPANT):</b> _____					\$ _____
<b>TOTAL GROSS HOUSEHOLD INCOME:</b>					\$ _____

**ADULT HOUSEHOLD MEMBER SIGNATURE and LAST FOUR DIGITS of SOCIAL SECURITY NUMBER:** (See Privacy Act Statement below)  
 An Adult Household Member must sign and date this form and list the last four (4) digits of his or her Social Security Number.  
 If you do not have a social security number, mark the box  I do not have a Social Security Number.

**PENALTIES FOR MISREPRESENTATION:** I certify that all of the above information is true and correct and that the Food Stamp, TANF, SSI, or Medicaid Number of the enrolled participant is correct, or that all income is reported. I understand that this information is being given for the receipt of Federal funds issued to the day care center based on the information I provide. I understand that CACFP officials may verify this information, and that deliberate misrepresentation may result in the participant losing meal benefits, and I may be prosecuted under the applicable State and Federal laws. *An Adult Household Member must complete the following:*

Signature: \_\_\_\_\_ Address: \_\_\_\_\_  
 Print Name: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Date: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Last four (4) digits of Social Security Number: \* \* \* \* - \* \* \* - \_\_\_\_\_  I do not have a Social Security Number

**PRIVACY ACT STATEMENT:** The National School Lunch Act requires that, unless the participant's Case Number is provided, you must include the Social Security Number of the adult household member signing the application or indicate that the household member does not have a Social Security Number. Provision of a Social Security Number is not mandatory, but if a Social Security Number is not given or an indication is not made that the signor does not have such a number, the participant cannot be determined eligible for free or reduced priced menus. The Social Security Numbers may be used to identify you for verifying the correctness of information stated on the application. These verifications may include audits, and investigations and may include contacting employers to determine income, contacting a Food Stamp or TANF office to determine current certification for receipt of Food Stamps or TANF benefits, contacting the State Employment Security office to determine the amount of benefits received and checking the documentation produced by household members to verify the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims or legal actions if incorrect information is reported. These acts must be told to all household members whose Social Security Numbers are reported on this form.

Determination: Free _____ Reduced _____ Paid _____ Signature of Determining Official: _____ Date: _____	<b>TOTAL MONTHLY INCOME \$</b> _____ <i>Conversion factors to figure monthly income: Weekly x 4.33                  Twice a month x 2                  Every 2 weeks x 2.15</i>
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