Glassboro Child Development Centers
Camp RASKEL 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)
Is your child fully potty trained? _____**Yes** _____**No**
If not, what size pull up? _____

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

Pricing:

Grade	Current RASKEL Students	All Others
PreK 3/4	$210	$300
K	$185	$275

We accept NJCK Voucher/WFNJ (additional fee may apply)
United in Care Tuition Assistance Available
There is no 2nd child discount.

- **MUST pay for the weeks registered whether they attend or not.**
- Breakfast & PM snack is provided.
- Must pack a totally disposable lunch.

Fees are **automatically** deducted every week.

All families are required to have an active ProCare account.

Please place a check next to the weeks your child will attend:

- ☐ Week 1: June 18-21 (40% off)
- ☐ Week 2: June 24-28
- ☐ Week 3: July 1-5 (40% off)
- ☐ Week 4: July 8-12
- ☐ Week 5: July 15-19
- ☐ Week 6: July 22-26
- ☐ Week 7: July 29-August 2
- ☐ Week8: August 5-9
- ☐ Week 9: August 12-16

Camp Horizon is made possible through funding from the United Way of Gloucester County and the County of Gloucester.

FOR STAFF USE ONLY:

PK3 PK4 K	Initial
Packet Complete	____
Fee Agreement	____
Registration Paid	____
1st Payment Paid	____
Parent Handbook Sent	____

	Initial
Enter/Update ProCare	____
CCFP-(1) copy file, orig. office	____
ER form-(2) copy office, site, orig. file	____
Photo (1) copy office, orig. file	____
File in Child's Confidential Folder	____
Welcome email sent: _____	____
Rutgers pre papas completed: _____	
Contract received: _____	

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: _____ **Religious Preference: (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®?		

Special situations or needs that staff should be aware of:
☐ Child has behavioral /emotional difficulties
☐ Child has physical disabilities
☐ 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.

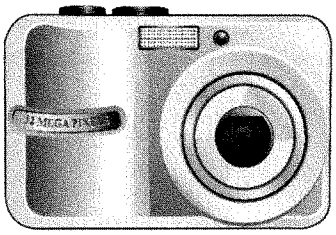
I understand that this consent will be in effect as of the date of my signing and will continue as long as my child is enrolled in GCDC programs.

_____

Parent/Guardian Signature Date

Glassboro Child Development Centers

Photo Release Form



Please select site:

- ☐ Preschool
- ☐ RASKEL@Rodgers
- ☐ Horizon @Bullock-Grades1-2
- ☐ JURASSIC@Bullock-Grades 3-5
- ☐ JURASSIC@Bowe-Grades 6-8

I, _____, herby ____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

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:

___ Administration of Medication
___ Breastfeeding *(Preschool Only)*
___ Communicable Diseases
___ Completion of Assessment *(Preschool Only)*
___ Diapering *(Preschool Only)*
___ Fee Policies
___ Hand Washing Guidelines
___ Information to Parents
___ Nutrition and Physical Activity
___ Parent Grievance
___ Right to Refuse Services
___ Screen Time
___ Supervision of Children
___ Toilet Training *(Preschool Only)*
___ Attendance *(Preschool Only)*
___ Discipline/Expulsion
___ Communication/Notification
___ Dental Health *(Preschool Only)*
___ Family Engagement
___ Transportation
___ Inaccessibility to Toxic Substances
___ Late Pick Up
___ Parent/Family Code of Conduct
___ Release of Children
___ Safe Sleep *(Preschool Only)*
___ Screening/Referral *(Preschool Only)*
___ Transition *(Preschool Only)*
___ 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

_____
Date

_____
Agency Witness

Names of child/children:
_____

_____

_____

**** 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.

_____

_____

_____

_____

_____

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: _____

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

*Special Notes: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

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

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

NAME(S) & AGE(S) OF ENROLLED PARTICIPANT(S)_____
(Name) *(Age)* *(Name)* *(Age)*

OPTIONAL: RACIAL/ETHNIC IDENTITY OF PARTICIPANT

Check one ETHNIC identity:

[ ] Hispanic or Latino [ ] Not Hispanic or Latino

Mark one or more RACIAL identity (ies):

[ ] American Indian or Alaska Native [ ] Asian [ ] Black or African American

[ ] Native Hawaiian or Other Pacific Islander [ ] White

Enrollment Information

*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: ☐MON ☐TUES ☐WED ☐THURS ☐FRI ☐SAT ☐SUN

HOURS OF CARE:
Swing / Rotating Shifts: (If Applicable) ___:___ ___:___ ___:___ ___:___ ___:___ ___:___ ___:___

MEAL TYPES SERVED: ☐BREAKFAST ☐A.M. SUPPLEMENT ☐LUNCH ☐P.M. SUPPLEMENT ☐DINNER

CHILD DAY CARE FOOD PROGRAM PARTICIPANTS ONLY

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)**

If you are now receiving SNAP,TANF or FDPIR for this child, complete **one** of the following numbers:

SNAP CASE #_____ *OR* TANF CASE #_____ *OR* FDPIR CASE #_____

OPTION 1B: FOSTER CHILD

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 $_____

ADULT DAY CARE FOOD PROGRAM PARTICIPANTS ONLY

OPTION 2: BENEFICIARIES of SNAP, FDPIR, SSI or Medicaid

If you are now receiving SNAP, SSI, FDPIR or Medicaid complete **one** of the following numbers:

SNAP #_____ *OR* FDPIR CASE #_____ *OR* SSI CASE #_____ OR MEDICAID CASE #_____

OPTION 3: HOUSEHOLD ELIGIBILITY - COMPLETE IF YOU DID NOT COMPLETE OPTION 1A, OPTION 1B, OR OPTION 2

Complete the following information: Household Members, Social Security Numbers and Income.

NAMES OF ALL OTHER HOUSEHOLD MEMBERS: (*Related and Unrelated*)	MONTHLY INCOME *(Complete One Or More - Before Deductions)*				
	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.	$	$	$	$	$
TOTAL NUMBER IN HOUSEHOLD *(INCLUDE ENROLLED PARTICIPANT)*: _____					
TOTAL GROSS HOUSEHOLD INCOME:				$ _____	

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 participants' 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 signer 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_____

TOTAL MONTHLY INCOME $_____
Conversion factors to figure monthly income: Weekly x 4.33
Twice a month x 2
Every 2 weeks x 2.15