Glassboro Child Development Centers
Camp JURASSIC Summer Learning Program
2025 Registration

Child's Name: _____ Date of birth: _____

Grade for 2024-2025 School Year: _____ Gender: M F **Shirt Size: Youth: S M L XL**

Adult: S M L XL

Parent's Name: _____

Address: _____ City_____ State: _____ Zip: _____

Telephone: _____ Email: _____

Does your child require any medication/special accommodations or have any allergies? *(If yes, there is additional forms required prior to enrollment/attending.)*	**_____Yes _____No**
Does your child have an IEP/504 Plan? *(If yes, must be received and accommodations in place before child begins)*	**_____ Yes _____No**
Is there a court order (custody or restraining order) involving this child?	**_____Yes _____No**

Registration Fees: $25 per child per week due at time of registration
Registration fees are non-refundable _____ *(initial here)*

Pricing:

Grade	Current JURASSIC Students		Out-of-District Weeks 1-8
	Weeks 1-4 Jun 23-Jul 18	Weeks 5-8 Jul 21-Aug 15	
3rd – 5th	Free	$225/week	$300/week
6th – 8th	Free	$200/week	$275/week

We accept NJCK Voucher/WFNJ
Various Tuition Assistance Programs Available
There is no 2nd child discount.

All families are required to have an active ProCare account.

Fees are **automatically** deducted every week

- **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.

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

- o Week 1: June 24-27 (20% off)
- o Week 2: June 30-July 3 (20% off)
- o Week 3: July 7-11
- o Week 4: July 14-18
- o Week 5: July 21-25
- o Week 6: July 28-August 1
- o Week 7: August 4-8
- o Week 8: August 11-15

Late Pick-ups

_____ Summer Learning Programs end at 5:30pm. If you are late picking up your child, there will be a cost of $1.00 per minute. Late fees are billed directly through the ProCare account, and an invoice is automatically generated and emailed to you. Please see the Parent Handbook for more information.

Program Requirements

_____ Students are expected to attend at least 80% of the time (4 days per week).
_____ Students and parents/guardians are expected to participate in surveys and forums that help with data collection needed for grant reporting throughout the year.
_____ Parents/guardians are expected to participate in family engagement activities at least three times per year.

Tuition Assistance

Childcare subsidy programs exist to help cover weekly tuition costs if eligible. Applying for tuition assistance can take some time so please do not delay this process. A VALID CONTRACT IS NEEDED BEFORE ANY CHILD CAN BEGIN.

Weeks 1-4

The 21st Century Community Learning Center is a federally funded program supported by the New Jersey Department of Education for out-of-school-time programs in New Jersey, which include those before school, after school or in the summer.

Weeks 5-8

____ If you are denied NJ State Child Care Subsidy, please check here for more information.

Camp JURASSIC is made possible in part through funding from the Juvenile Justice Commission.

FOR STAFF USE ONLY:								
3	4	5	6	7	8	Initial		Initial
Packet Complete						____	Enter/Update ProCare	____
Fee Agreement						____	CCFP-(1) copy file, orig. office	____
Registration Paid						____	ER form-(3) copy file, office, site, orig. file	____
1st Payment Paid						____	Photo (1) copy file, orig. office	____
Welcome Email						____	Tuition Express form-orig. Deanna	____
Verification							File in Child's Confidential Folder	____
							Start Date	____

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.

Child'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®?		

Does your child have any special needs that staff should be aware of?

- ☐ Child has behavioral /emotional challenges
- ☐ Child has physical disabilities
- ☐ Child has IFSP, IEP, or 504 Plan.

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, and/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 the duration of my child's enrollment with GCDC programs.

_____

Parent/Guardian Signature Date

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: _____

Parent/Guardian Name: _____

Relationship to Child: _____

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: _____

FOR OFFICE USE ONLY:

- ☐ Classroom
- ☐ Social Media
- ☐ Print Media

7/2024

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
___ Diapering
___ 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
___ Visiting Consultants/Therapists
___ 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.**

7/2024

2025 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* ☐ *SUPPER*

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 CASE # _____ *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 Other 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