



## Glassboro Child Development Centers Camp RASKEL 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**

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  
*(If yes, there is additional forms required prior to enrollment/attending.)*

**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)*

**PRE-K CHILDREN ONLY:** I acknowledge that my child is fully potty trained and does not require pull-ups or diapers while attending the RASKEL program. \_\_\_\_\_ *(initial here)*

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

**Pricing:**

Grade	Current RASKEL Students	All Others
PreK 4/K	\$250/week	\$325/week
1 <sup>st</sup> / 2 <sup>nd</sup>	\$225/week	\$300/week

*We accept NJCK Voucher/WFNJ (additional fee may apply)*

*Various Tuition Assistance Programs Available*

***There is no 2<sup>nd</sup> child discount.***

- **MUST pay for the weeks registered whether they attend or not.**
- Breakfast & PM snacks are provided.
- Must pack a totally disposable lunch.
- **All PreK 4 children must have turned 4 years old on or before October 1, 2024.**

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:

<input type="checkbox"/> Week 1: June 24-27 (20% off) <input type="checkbox"/> Week 2: June 30-July 3 (20% off) <input type="checkbox"/> Week 3: July 7-11 <input type="checkbox"/> Week 4: July 14-18	<input type="checkbox"/> Week 5: July 21-25 <input type="checkbox"/> Week 6: July 28-August 1 <input type="checkbox"/> Week 7: August 4-8 <input type="checkbox"/> Week 8: August 11-15
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*Camp RASKEL is made possible in part through funding from the United Way of Gloucester County and the County of Gloucester.*

<b><u>FOR STAFF USE ONLY:</u></b>		Initials			
PK4	K	1	2		
Packet Complete				Initials	_____
Fee Agreement				_____	
ProCare Setup				_____	
Registration Paid				_____	
1 <sup>st</sup> Payment Paid				_____	
Welcome Email				_____	
Verification				_____	
				Enter/Update ProCare	_____
				Cover sheet (orig. file, copy Fin. Dir.)	_____
				ER Form (orig. file, copy office, site ER books)	_____
				Photo Release (orig. file, copy office)	_____
				CACFP (orig. office, copy file)	_____
				Update Child File	_____
				Child File to Site Dir	_____
				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: \_\_\_\_\_  
Phone #: \_\_\_\_\_

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Relationship: \_\_\_\_\_  
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: _____	<b>Religious Preference:</b> <b>(optional)</b> _____
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®?		

<p><b>Does your child have any special needs that staff should be aware of?</b></p> <p><input type="checkbox"/> Child has behavioral /emotional challenges</p> <p><input type="checkbox"/> Child has physical disabilities</p> <p><input type="checkbox"/> Child has IFSP, IEP, or 504 Plan.</p>
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**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.

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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, \_\_\_\_\_, 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: \_\_\_\_\_

**FOR OFFICE USE ONLY:**

- Classroom
- Social Media
- Print Media

# 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                | <input type="checkbox"/> Dental Health ( <i>Preschool Only</i> )      |
| <input type="checkbox"/> Diapering                               | <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                         | <input type="checkbox"/> Use of Technology and Social Media           |
| <input type="checkbox"/> Visiting Consultants/Therapists         |   |

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.**

**2025 NEW JERSEY CHILD AND ADULT CARE FOOD PROGRAM  
ELIGIBILITY APPLICATION**

<b>NAME(S) &amp; AGE(S) OF ENROLLED PARTICIPANT(S)</b>					
	<i>(Name)</i>	<i>(Age)</i>			
	<i>(Name)</i>	<i>(Age)</i>			
<p><i>OPTIONAL - RACIAL/ETHNIC IDENTITY OF PARTICIPANT</i></p> <p>Check one ETHNIC identity:</p> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino					
<p>Mark one or more RACIAL identity (ies):</p> <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:					
<b>DAYS OF CARE:</b>	<b>MON</b>	<b>TUES</b>	<b>WED</b>		
	<b>THURS</b>	<b>FRI</b>	<b>SAT</b>		
	<b>SUN</b>				
<b>HOURS OF CARE:</b>	-	-	-		
<i>Swing / Rotating Shifts: (If Applicable)</i>	-	-	-		
<b>MEAL TYPES SERVED:</b>	<input type="checkbox"/> BREAKFAST	<input type="checkbox"/> A.M. SUPPLEMENT	<input type="checkbox"/> LUNCH		
	<input type="checkbox"/> P.M. SUPPLEMENT	<input type="checkbox"/> SUPPER			
<b>CHILD DAY CARE FOOD PROGRAM PARTICIPANTS ONLY</b>					
<b>OPTION 1A:</b> 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 <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 <input type="checkbox"/>	INCOME \$ _____				
<b>ADULT DAY CARE FOOD PROGRAM PARTICIPANTS ONLY</b>					
<b>OPTION 2:</b> 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 # _____			
<b>OPTION 3: HOUSEHOLD ELIGIBILITY - COMPLETE IF YOU DID NOT COMPLETE OPTION 1A, OPTION 1B, OR OPTION 2</b>					
<i>Complete the following information: Household Members, Social Security Numbers and Income.</i>					
<b>NAMES OF ALL OTHER HOUSEHOLD MEMBERS:</b> <i>(Related and Unrelated)</i>	<b>MONTHLY INCOME (Complete One Or More - Before Deductions)</b>				
	<i>Monthly (Gross Earnings) Wages/Salary</i>	<i>MONTHLY SOCIAL SECURITY PENSIONS / RETIREMENT</i>	<i>MONTHLY UNEMPLOYMENT WORKER'S COMPENSATION</i>	<i>MONTHLY WELFARE, CHILD SUPPORT, ALIMONY</i>	<i>Monthly Any Other Income</i>
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> _____					\$ _____
<b>ADULT HOUSEHOLD MEMBER SIGNATURE and LAST FOUR DIGITS of SOCIAL SECURITY NUMBER:</b> <i>(See Privacy Act Statement below)</i>					
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 - <input type="checkbox"/> "I do not have a Social Security Number."					
<b>PENALTIES FOR MISREPRESENTATION:</b> 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. <i>An Adult Household Member must complete the following:</i>					
Signature: _____			Address: _____		
Print Name: _____		City: _____		State: _____ Zip Code: _____	
Date: _____			Phone Number: _____		
Last four (4) digits of Social Security Number: * * * - * * *					<input type="checkbox"/> I do not have a Social Security Number
<b>PRIVACY ACT STATEMENT:</b> 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: <input type="checkbox"/> Reduced: <input type="checkbox"/> Paid: <input type="checkbox"/>			<b>TOTAL MONTHLY INCOME \$</b> _____		
Signature of Determining Official: _____			<i>Conversion factors to figure monthly income: Weekly x 4.33 Twice a month x 2 Every 2 weeks x 2.15</i>		
Date: _____					