Date_____

Glassboro Child Development Centers

School Age Expanded Learning Program

Registration Form - Grades 6-8

Student's Name: _____

Age: _____ Grade: _____ Date of Birth: _____

Parent's Name: _____ Start Date: _____

Email: _____

Teacher's Name: _____

Does your child have an IEP, 504 plan or medications? ☐ YES ☐ NO

**See below*

If yes, GCDC *requires* documentation for review prior to enrollment. GCDC may need additional time and resources to develop reasonable accommodations for your student. This may delay enrollment and start date.

****There is no AM care at this location.****

Please Initial:

Late Pick-up

_____ All GCDC School-Age Programs end at 6:00pm. 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 will be automatically generated and emailed to you. For more information regarding our Late Pick-Up Policy, please refer to the Parent Handbook.

21st Century Community Learning Center

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.

PROCARE Enrollment and Communication App

_____ All families are required to create a ProCare account at time of registration by downloading the ProCare Parent app to their cellphone. Please note, you are not fully registered until your ProCare account is confirmed. This app is used for all communication, including attendance, payments, weekly/monthly calendars, parent/staff communication and other news.

*****TURN TO OTHER SIDE*****

Program Requirements

_____ Student are expected to attend at least 80% of the time (4 days per week).

_____ Students and parents/guardian 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.

Reasonable Accommodations for Children with Special Needs

____ All applicable documentation is to be attached to assist in determining GCDC's ability to reasonably accommodate a child's special need; the ISFP, IEP, or 504 documents serve as guidance. As a childcare provider we meet the ADA requirements, please note GCDC is not a public school.

_____ Upon receipt of all documentation, an enrollment meeting may be conducted to confirm registration is complete and active.

Medication

_____ If your child requires medication, it must be provided along with medical forms that can be picked up at our main office.

_____ All medications are to be in their original packaging with the pharmacy label with the child's information on it.

_____ Upon receipt of all documentation, an enrollment meeting may be conducted to confirm registration is complete and active

FOR STAFF USE ONLY:			
Grade: 3 4 5	*Initial*		*Initial*
Packet Complete	_____	Photo Release (1) copy file, orig. office	_____
Fee Agreement	_____	CCFP (1) copy, orig. office	_____
Registration Paid	_____	ER Form (2) copy file, copy office, orig. site	_____
1st Week Paid	_____	Medication, IEP, 504 Plan (1) copy file, orig. site	_____
Set up ProCare Acct. w/ Parent	_____	Update/Create Child's Folder	_____
Enter/Update ProCare		Tuition Assistance Contract Received *Date 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.

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

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

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: _____

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

2024-2025 CHILD AND ADULT CARE FOOD PROGRAM LETTER TO PARENT/PARTICIPANT

Dear Parent/Participant:

Our agency depends on Child and Adult Care Food Program funds to provide meals at no separate charge to all participants. Complete information is necessary in order to receive the maximum funds available through the United States Department of Agriculture. The information will serve as documentation that our enrolled participants are eligible for the Child and Adult Care Food Program. You may complete and submit one CACFP eligibility application for all participants from the same household that are enrolled for care with our agency.

Household members include everyone in your household (such as grandparents, other relatives, or friends who live with you) who share income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you. Once properly categorized for free or reduced price benefits, whether through income or by providing a current SNAP, FDPIR, or TANF case number (SNAP, FDPIR, SSI, or Medicaid case number for Adult Day Care Participants), you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within those eligibility standards.

The income that you report must be the total gross income received by all members of your household.

The "Eligibility Income Scale" for reduced-price meals is included in this letter for your information. If your income is less than or equal to these reduced- priced standards, the participant is eligible for free or reduced-price meals from the Child and Adult Care Food Program, which means increased reimbursement for our center and increased nutritional benefits for the participant.

Please complete, sign and return the form so that our center may receive maximum reimbursement. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. This form will be placed in our files and treated as confidential information. Your cooperation is vital and appreciated.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866)-632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by: 1. U.S Department of Agriculture, Office of the Assistant of Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250; or 2. Fax (833) 256-1665 or (202) 690-7442; or 3. Email: program.intake@usda.gov

Glassboro Child Development Centers	(856) 881-3331
(Name of Day Care Center)	*(Day Care Center Phone Number)*
New Jersey Department of Agriculture Child and Adult Care Food Program	*Phone Number 609-984-1250*

TO APPLY, YOU MUST COMPLETE ONE OF THREE OPTIONS.

1. List the Name of the participant *(First and Last Names).*
2. Complete the Days, Hours of Care, and the meal types served to the enrolled participant. (*One time requirement for Adult Day Care participants*)

Option 1A or 1B - CHILD CARE PARTICIPANTS ONLY:

If you receive SNAP, TANF, or FDPIR benefits for the participant, list the SNAP, TANF or FDPIR Case Number and Sign and Date the form.

If you are applying for a **Foster Child** who is under the legal responsibility of the welfare agency or court, Check the Box and Sign and Date the form.

A FOSTER CHILD'S PERSONAL USE INCOME is defined as follows:

a) Funds received from a welfare agency, which can be identified for personal use of the child. Where funds provided by the welfare agency are specified by agency, i.e., funds for shelter and care; special needs funds; and funds for personal needs such as clothing, school fees, allowances, etc., only those funds that can be identified as personal use funds shall be considered as income.

b) Money received in hand from any source. This includes, but is not limited to, funds received from trust accounts, monies provided by the child's family for personal use and earnings from employment other than occasional or part-time (e.g., paper routes, baby-sitting).

Option 2 – ADULT CARE PARTICIPANTS ONLY

If you receive SNAP, FDPIR, SSI or Medicaid benefits for the participant, indicate the SNAP, FDPIR, SSI or Medicaid Case Number and Sign and Date the form.

Option 3 – CHILD CARE AND ADULT PARTICIPANTS:

If you do not receive SNAP, TANF, FDPIR, SSI or Medicaid benefits for the participant, you must complete:

1. Names of all *(Related or Unrelated)* household members
2. List the household income *(Monthly Gross Earnings)* for each household member.
3. Total number in household *(#1 + #3 above).*
4. Total the gross income of all household members.
5. Sign, Print and complete the full address of the Adult Household Member signing the application.
6. Date the form and complete the telephone number of Adult Household Member signing the application.
7. List the last four (4) digits of the social security number for the Adult Household Member signing the application or indicate that the Adult Household Member signing the application does not possess a social security number.

ELIGIBILITY INCOME SCALE
Effective From July 1, 2024 to June 30, 2025

HOUSEHOLD SIZE	REDUCED		
	ANNUAL	MONTHLY	WEEKLY
1	$19,579 - $27,861	$1,633 - $2,322	$ 378 - $ 536
2	$26,573 - $37,814	$2,216 - $3,152	$ 512 $ 728
3	$33,567 - $47,767	$2,799 - $3,981	$ 647 - $ 919
4	$40,561 - $57,720	$3,381 - $4,810	$ 781 - $1,110
5	$47,555 - $67,673	$3,964 - $5,640	$ 916 - $1,302
6	$54,549 - $77,626	$4,547 - $6,469	$1, 050 - $1,493
7	$61,543 - $87,579	$5,130 - $7,299	$1,185 - $1,685
8	$68,537 - $97,532	$5,713 - $8,128	$1,319 - $1,876
Each Additional Family Member	+9,953	+830	+192