



Glassboro Child Development Centers

2026-2027 School Age Expanded Learning Program

JURASSIC Registration Forms

Student's Name: _____

Age: _____ Grade: Bullock 3 4 5 Date of Birth: _____

Bowe 6 7 8 Sex: ____ Male ____ Female

Parent's Name: _____ Hispanic Latino: ☐ YES ☐ NO

Primary Home Language: _____ Race: _____

Email: _____

Teacher's Name: _____

Does your child have an ☐ IEP, ☐ 504 plan or ☐ medications? **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.*

Select enrollment: AM only ____ PM only ____ AM/PM ____ Drop-in ____

Child Care Resources: ☐ WFNJ ☐ NJCK ☐ DCP&P

Case Worker: _____ Phone: _____

Late Pick-up

_____ GCDC Programs end at 5:30pm, all students are expected to be picked up by 5:25pm. If you are late picking up your child, there will be a cost of \$1.00 per minute, which will be billed directly through the ProCare account within the week. An invoice will be automatically generated and emailed. For more information regarding our Late Pick-Up Policy in our Parent Handbook.

Fees and Costs/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.

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 ADA requirements; although our programs use the district buildings, please note GCDC is not a public school.

Medication

_____ If your child requires medication, it must be provided 2 days prior to the child's start date, 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.

Program Requirements

_____ Student are expected to attend at least 80% of the time enrolled.

_____ 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.

Child Release

_____ I certify that the information I've provided about my child's legal parents/guardians is accurate to the best of my knowledge. I understand this will guide pickup authorization and parental communication unless legal documentation is provided to the contrary.

_____ **Both legal parents have equal rights to pick up their child unless we are provided with a court order stating otherwise.** If only one parent is listed on the emergency contact form and no legal documentation has been submitted, we are still obligated to release the child to the other legal parent.

_____ In the absence of a court order, **both parents are presumed to have equal rights** to pick up or access the child, regardless of who enrolled the child. If a parent wishes to restrict the other parent's access, they must provide the center with a **valid, current court order**. The center will retain a copy and enforce it accordingly.

_____ GCDC does not collect or require proof of maternity or paternity at time of enrollment and will rely on parental declarations and documented authorizations of either. Once verbal or written acknowledgement exists of maternity or paternity, GCDC will recognize that individual as a legal parent until provided proof otherwise or until a court document alters parent access.

Parent Acknowledgement

_____ I understand that once all required documents have been submitted, an enrollment meeting may be scheduled to review application details and finalize next steps before my child may begin.

_____ By signing below, I confirm that the information provided in this GCDC application is complete and accurate to the best of my knowledge.

Parent Name (Print): _____

Parent Signature: _____



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)

**In the absence of a court order, both parents are presumed to have equal rights to pick up or access the child, regardless of who enrolled the child. If a parent wishes to restrict the other parent's access, they must provide the center with a valid, current court order. The center will retain a copy and enforce it accordingly.*

IN THE EVENT OF AN EMERGENCY – PARENTS ARE CONTACTED FIRST.

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: _____

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.

☐ Yes ☐ No

Child has physical disabilities.

☐ Yes ☐ No

Child has IFSP, IEP, or 504 Plan.

☐ Yes ☐ No

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 to 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 of attendance:

☐
☐
☐

Preschool-Main

Preschool-Ellis

RASKEL-Grades PK 3-K

☐
☐

HORIZON-Grades 1-5



Child's Full Name: _____

Date of Birth: _____

Parent/Guardian Name: _____

I, the undersigned, hereby grant permission to Glassboro Child Development Centers to use photographs, video, or other images of my child for the purposes listed below:

- ☐ Social Media (e.g., Facebook, Instagram, Twitter)
- ☐ GCDC Website and E-newsletters
- ☐ Print Media (newsletters, brochures, flyers, newspapers, etc.)

These images may be used for informational, promotional, and educational purposes, and may be published in print or digital formats. I understand that my child's full name **will not be used** unless I give specific written consent.

I understand that I may revoke this consent at any time in writing, but that revocation will not affect any use already made prior to the revocation.

Consent Options (please check one):

- ☐ I **give** permission for my child's image to be used as indicated above.
- ☐ I **do not give** permission for my child's image to be used.

Signature of Parent/Guardian: _____ **Date:** _____

Parent/Guardian Contact Information:

Phone: _____ **Email:** _____

PARENT HANDBOOK /POLICY RECEIPT ACKNOWLEDGEMENT



Dear Parent:

In keeping with New Jersey's childcare 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 | ☐ Attendance (<i>Preschool Only</i>) |
| ☐ Breastfeeding (<i>Preschool Only</i>) | ☐ Discipline/Expulsion |
| ☐ Communicable Diseases | ☐ Communication/Notification |
| ☐ Completion of Assessment | ☐ Dental Health (<i>Preschool Only</i>) |
| ☐ Diapering | ☐ Family Engagement |
| ☐ Fee Policies | ☐ Transportation |
| ☐ Hand Washing Guidelines | ☐ Inaccessibility to Toxic Substances |
| ☐ Information to Parents | ☐ Late Pick Up |
| ☐ Nutrition and Physical Activity | ☐ Parent/Family Code of Conduct |
| ☐ Parent Grievance | ☐ Release of Children |
| ☐ Right to Refuse Services | ☐ Safe Sleep (<i>Preschool Only</i>) |
| ☐ Screen Time | ☐ Screening/Referral (<i>Preschool Only</i>) |
| ☐ Supervision of Children | ☐ Transition (<i>Preschool Only</i>) |
| ☐ Toilet Training | ☐ Use of Technology and Social Media |
| ☐ 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.**

**2027 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:		Mark one or more RACIAL identity (ies):	
☐ Hispanic or Latino	☐ Not Hispanic or Latino	☐ American Indian or Alaska Native	☐ Asian
		☐ Native Hawaiian or Other Pacific Islander	☐ Black or African American
			☐ White
Enrollment Information			
<i>Check () each day the above participant is enrolled for care, the hours of care each day, and the meal type(s) served:</i>			
DAYS OF CARE:	☐ MON	☐ TUES	☐ WED
	☐ THURS	☐ FRI	☐ SAT
	☐ SUN		
HOURS OF CARE:			
<i>Swing / Rotating Shifts: (If Applicable)</i>			
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 <u>one</u> 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 <u>one</u> 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 (Gross Earnings)	MONTHLY INCOME (Complete One Or More - Before Deductions)			Monthly Any Others Income
	Wages/Salary	MONTHLY SOCIAL SECURITY PENSIONS RETIREMENT	MONTHLY UNEMPLOYMENT WORKER'S COMPENSATION	MONTHLY WELFARE CHILD SUPPORT ALIMONY	
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 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: _____ ☐ 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 signer does not have such a number, the participant cannot be determined eligible for the reduced priced meals. 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 Food Stamp or TANF offices 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 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 application.	
Determination: Free _____ Reduced _____ Paid _____	TOTAL MONTHLY INCOME \$ _____
Signature of Determining Official: _____	<i>Conversion factors to figure monthly income: Weekly x 4.33</i>
Date: _____	<i>Twice a month x 2</i>
	<i>Every 2 weeks x 2.15</i>

2025-2027 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, FDIPIR, or TANF case number (SNAP, FDIPIR, 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-price 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, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family household status, income derived from a public housing program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the State or local agency that administers the program or contact USDA through the Telecommunications Relay Service at (1) 800-845-5500 and (1) 800-845-5501. Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-302, found online at <http://www.usda.gov> or at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail, U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Mail Stop 9410, Washington, DC 20250-9410; (2) fax, (202) 690-7412; or (3) email, program.discrimination@usda.gov.

USDA is an equal opportunity provider, employer, and lender.

Glassboro Child Dev. Ctrs

(Name of Day Care Center)

(856) 881-3331

(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 (this section is required for Adult Day Care participants)

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

If you receive SNAP, TANF, or FDIPIR benefits for the participant, list the SNAP, TANF or FDIPIR 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:

is funds received from a welfare agency which can be identified for personal use of the child. When funds provided by the welfare agency are specified by the agency, i.e., funds for shelter and other 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.

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, babysitting).

Option 2 - ADULT CARE PARTICIPANTS ONLY:

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

(Name of Day Care Center)

Option 3 - CHILD CARE AND ADULT PARTICIPANTS:

New Jersey Department of Agriculture Child and Adult Care Food Program

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

3. Name, of all (related or unrelated) household members
4. List the household income (Monthly Gross Earnings) for each household member
5. Total number in household (1 - 3 above)
6. Total gross income of all household members
7. Sign, Print and complete the full address of the Adult Household Member signing the application
8. Date the form and complete the telephone number of Adult Household Member signing the application
9. 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, 2026 to June 30, 2027

HOUSEHOLD SIZE	REDUCED		
	ANNUAL	MONTHLY	WEEKLY
1	\$20,749 - \$29,526	\$1,730 - \$2,461	\$ 400 - \$ 568
2	\$28,133 - \$40,034	\$2,346 - \$3,337	\$ 542 - \$ 770
3	\$35,517 - \$50,542	\$2,961 - \$4,212	\$ 684 - \$ 972
4	\$42,901 - \$61,050	\$3,576 - \$5,088	\$ 826 - \$1,175
5	\$50,285 - \$71,558	\$4,192 - \$5,964	\$ 968 - \$1,377
6	\$57,669 - \$82,066	\$4,807 - \$6,839	\$1,110 - \$1,579
7	\$65,053 - \$92,574	\$5,422 - \$7,715	\$1,252 - \$1,781
8	\$72,437 - \$103,082	\$6,038 - \$8,591	\$1,394 - \$1,983
Each Additional Family Member	+10,508	+876	+203

CACFP Notice to Participant/Parent Letter/6/10/2026