Glassboro Child Development Centers

2026-2027 School Age Expanded Learning Program

RASKEL at Rodgers Registration Form

Grades PK3-K

Student's Name: _____

Age: _____ Grade: PK3 PK4 K Date of Birth: _____

Parent's Name: _____ Sex: ____ Male ____ Female

Primary Home Language: _____ Hispanic Latino: ☐ YES ☐ NO

Email: _____ Race: _____

Teacher's Name: _____

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

Is your child fully potty trained? ☐ YES ☐ NO

*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 _____

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

Case Worker: _____ Phone: _____

Please initial the statements below:

Late Pick-up

_____GCDC Programs end at 6:00pm, all students are expected to be picked up by 5:55pm. 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

_____ A nonrefundable registration fee of $50 per child and first week's payment are due at the time of enrollment. You are expected to create a ProCare account at the time of enrollment, and all fees are paid through the app. Payments are automatically deducted every Sunday. *Tuition assistance programs may help cover some of these fees.*

Program Requirements

_____ 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.

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.

Continue to the next page >>

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: _____

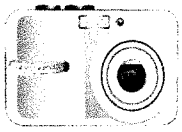
Authorized Pick-Up #4

Name: _____ Relationship: _____
Phone #: _____ Address: _____

Authorized Pick-Up #5

Name: _____ Relationship: _____
Phone #: _____ Address: _____

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: _____

BLANKET PERMISSION SLIP

Please select site of attendance:

- ☐ Preschool-Main
- ☐ Preschool-Ellis
- ☐ RASKEL-Grades PK 3-K
- ☐ HORIZON-Grades 1-5

Child's Name: _____

By signing below, you are giving permission for your child to participate in the following activities and services provided by Glassboro Child Development Centers (GCDC):

- Supervised activities held at the center
- Supervised neighborhood walks
- Emergency medical or dental treatment, as deemed necessary by qualified personnel or emergency responders in Glassboro. Treatment may be provided in a doctor's or dentist's office or at a hospital.

By signing this form, you acknowledge that your child is in good health and able to participate in the regular activities of the GCDC programs. If your child has any health conditions, allergies, or special needs requiring accommodation, please describe them below:

_____

_____

_____

*Note: A specific permission slip will be provided for each field trip.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

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
___ 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.**

2026 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 a 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 thi 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 Membe 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 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 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