2018 -2019 Holy Trinity Catholic School Before & After Care Guidelines

There will be significant changes to our Morning and After Care Program for the 2018 -2019 year.
Please read this document carefully.

Our program will now follow the Department of Human Services regulations for operating a child care facility. This regulation provides the rules regarding operation of a child day care center. A child day care center must have a certificate of compliance (license) from DHS in to order to operate.
https://www.pacode.com/secure/data/055/chapter3270/chap3270toc.html

The Before Care & After Care Programs at Holy Trinity Catholic School were created with working parents in mind. For a small hourly fee, parents can rest assured that their child(ren) are in a safe and nourishing environment outside of the normal school hours. Regular hours of operation for After Care are 3:00pm – 6:00pm. This year there will be a limited number of spots available so you must email two week in advance. If you register and do not use the service you will be billed so be sure to go to the website to delate your spot. Parents using the program on a regular basis will have 1st priority.

Guidelines: ****RETAIN A COPY OF THIS FORM FOR YOUR RECORDS****

- The Child Health Report form and registration form and registration fee must be sent in by the first day of school to be able to use this service. These forms are attached to the guideline sheet.
- The yearly registration fee for one child is $35.00 and the family rate is $60.00. This fee must be paid before you can use the service.
- To sign up for a spot for Before and After Care go to http://signup.com/go/ZKckaPj. Your child must be registered prior to using this service. If you sign up and do not use the service you will be billed for the time and day you reserved the spot. You must cancel 24 hours in advance on signup.com
- The program follows the school calendar. When school is closed for any part of the day the program is closed.
- Before Care & After Care will begin on the first day of the school year which is August 27th.
- Before Care drop off will be at the main school door at 6:45am
- After Care will be held in the cafeteria. Please use the cafeteria doors for pick up.
- If school closes early do to an emergency or severe weather or if weather conditions become severe during After Care, parents should pick up their child(ren) as soon as possible.
- Parents are responsible to keep all contact information current for contact and billing purposes.
- For our information and your child's safety, we must have on record who will be picking your child(ren) up. If the person picking up your child(ren) is not listed on your Registration form, you will need to send a note that day to notify the staff. Without this note, the staff cannot release your child(ren). Identification will be required for the person picking up your child(ren).
- Families will be billed via email at the beginning of each month for the prior month's service. Payment is due on the on 15th of each month. If the payment is not received, the balance will be added to your Smart Tuition immediately and your child will removed from the program for 1 month. Non-sufficient fund checks will be charged a $40.00 fee.
- The After Care program ends promptly at 6:00pm. A **$1.00** per minute charge will be incurred after 6:00pm.
- The After Care program begins with a gathering time and snack, outside play if weather permits, quiet time for homework or watching a movie, computer time, and free play.
- Children should bring a snack.
- Children are entitled to a pleasant and harmonious environment. The After Care program cannot serve children who display disruptive behavior. If a child cannot adjust to the setting and behave appropriately, the child will be discharged.
- If special billing arrangements are needed please contact the school office.
- Invoice details are attached to the monthly bill, please keep a copy for your taxes.

2018 – 2019 Holy Trinity Catholic School Before Care & After Care Program Registration Form

Required Information

Mother (Guardian) ____________________________ Father (Guardian) ________________________________

Email address for bills to be sent to____

Phone number Mother (Guardian) __________________Phone number Father (Guardian)_____________

List the names and grades of your children who will be using the program.

First and Last name of Student ______________________________ Grade _________ First and Last name of Student _____________________________ Grade _________

Before And After Care Fees

Fees:	1Hour	2 Hours	3 Hours
	Monday- Friday		
1st Child	$7.00	$5.00 ($12.00)	$5.00 ($17.00)
2 or more children	$7.00	$3.00 ($10.00)	$3.00 ($13.00)

Authorized and Emergency Pick Up: Including yourself, please list anyone you authorize to pick up your child(ren) and who can be contacted in case of an emergency. Please list 2 numbers for each contact. Children will only be released to these individuals unless a note is sent in. Please inform the authorized person to be prepared to show identification.

Parent/ Guardian: ______________________________2 Phone Numbers _______________________________________

Parent/ Guardian: ______________________________2 Phone Numbers_______________________________________

Authorized Person:______________________________2 Phone Numbers_______________________________________

Please list any medical conditions, allergies or concerns that the staff should be aware of:

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I understand the terms of the After Care programs and will adhere to the guidelines. The After Care programs cannot serve children who display disruptive behavior. If a child cannot adjust to the setting and behave appropriately, the child will be discharged.

Parent/Guardian Name/Signature(s):

____________________________________ ____________________________________Date____________________________

Print Name Signature

____________________________________ ____________________________________Date____________________________

Print Name Signature

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

Parents may write immunization dates; health professional should verify and complete all data.

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

Screening	
VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	**DATE**	**DATE**	**DATE**	**DATE**	**DATE**	**COMMENTS**
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:		TITLE:
	PHONE:	LICENSE NUMBER: DATE FORM SIGNED: