



Michael Lynch, Executive Director
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FOR OFFICE USE ONLY
 RC C1
 RP C2
 BC A

REGISTRATION FORM 2024 - 2025 SCHOOL YEAR

In our 21st year, the Sea Cliff, Glenwood Landing, and Glen Head Elementary School Cafeterias are the sites for the Before/After School Program. A Not-for-Profit, the program is open when school is in session, ½ Days of School and Parent / Teacher Conference Days, to students **Grades K – 5** enrolled in the NS Central School District.

Our Program includes guidance /materials to complete daily homework assignments, outdoor recreation, Arts and Crafts, Board Game, Puzzle and building centers, a monthly calendar of special events and socialization with friends!
 Additional Enrichment Programs will be offered monthly.

Each program is open from **7:00 AM until the start of school 8:30 AM** and **from dismissal 2:40 PM until 6:00 PM**. We offer a flexible schedule: Choose from 1 to 5 days per week, mornings and /or afternoons OR on an “as needed” basis.

Morning Session:

\$8.50 per session per student if dropped off between 7:31 – 8:15 AM
 \$15.75 per session per student if dropped off between 7:00-7:30 AM

Afternoon Session:

\$16.50 per session from dismissal @ 2:40 PM – 4:00 PM
 \$28.50 per session per student from dismissal @ 2:40 – 4:01-6:00 PM

Half Days of School, Parent/Teacher and Supt’s Conference Days:

\$13.75 per hour per student
 20% sibling discount - always

To register, please complete this entire form (one form per student enrolled), complete w/signature, and mail it along with the annual registration fee check (no sibling discount on registration fee) to the address at the top of this form or Scan/Email the forms, to NSbefore.after@gmail.com. The Registration fee can also be paid online after the forms are received. Registration Fee: **\$90.00** if registered **Before August 1. \$100 AFTER August 1.**

REGISTER NOW – PLEASE PRINT CLEARLY!

Student Name _____ Date of Birth _____

Parent(s) / Guardian _____

Home Address _____

City _____ Zip Code _____

EMAIL address for billing: _____ @ _____

Grade / Teacher / School _____ / _____ / _____

Exact Start Date: _____

Scheduled Mornings / Afternoons:

| | |
|---------------|---------------------|
| Mon AM _____ | Arrival time: _____ |
| Tue AM _____ | _____ |
| Wed AM _____ | _____ |
| Thur AM _____ | _____ |
| Fri AM _____ | _____ |

| | |
|---------------|-----------------------------|
| Mon PM _____ | from dismissal until: _____ |
| Tue PM _____ | until: _____ |
| Wed PM _____ | until: _____ |
| Thur PM _____ | until: _____ |
| Fri PM _____ | until: _____ |

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
DAY CARE ENROLLMENT

| | | | | |
|---------------------------|---------------------------------|--|--|---------|
| PHOTO OF CHILD (Optional) | Child's Full Name: | | Date of Birth: / / | Gender: |
| | Preferred Name/Nickname: | | | |
| | Child's Home Address: | | | |
| | Name of Person Enrolling Child: | | Relationship to Child: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Caretaker <input type="checkbox"/> Relative _____ <input type="checkbox"/> Other _____ | |

| | |
|---|--|
| Phone Number(s) of Person Enrolling Child: () - <input type="checkbox"/> ok to text | Address of Person Enrolling Child (if different than child): |
| Email Address: | |

| EMERGENCY INFO | EMERGENCY CONTACT NAMES / ADDRESSES | Authorized to Pick Up Child | PRIMARY PHONE NUMBER | OTHER PHONE NUMBER / EMAIL |
|----------------|-------------------------------------|---|-------------------------------------|-------------------------------------|
| | Primary Contact: | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> ok to text | <input type="checkbox"/> ok to text |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> ok to text | <input type="checkbox"/> ok to text |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> ok to text | <input type="checkbox"/> ok to text |

| | |
|---|--|
| For Program Use Only Date of Enrollment: / / | For Program Use Only Date of Disenrollment: / / |
|---|--|

| | |
|--------------------|--------------------|
| Child's Full Name: | Date of Birth: / / |
|--------------------|--------------------|

Check boxes below to indicate if your child has any special needs/services: None

Early Intervention/Special Education
 Occupational Therapy
 Speech/Language
 Physical Therapy

Allergies (list) _____

Other _____

| | |
|---|-------------------------|
| Child's Primary Care Physician's Name/ Group: | Phone Number: () - |
| Preferred Hospital: | Phone Number: () - |
| Child's Dental Care: | Phone Number: () - |

Child health insurance information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: <https://nystateofhealth.ny.gov/>

- AGREEMENTS**
- I consent to emergency medical treatment for my child..... Yes No
 - I consent for my child to take part in neighborhood trips (i.e., library, park and playground) away from the program under proper supervision..... Yes No
 - I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips..... Yes No
 - I provided information on my child's special needs to the program to assist in caring for my child..... Yes No
 - I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation..... Yes No
 - I agree to review and update this information whenever a change occurs and at least once every year..... Yes No

| | |
|--|-----------|
| SIGNATURE - PARENT OR PERSON(S) LEGALLY RESPONSIBLE: | DATE: / / |
|--|-----------|