



Michael Lynch, Executive Director
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FOR OFFICE USE ONLY
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 RP C2
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REGISTRATION FORM 2026 - 2027 SCHOOL YEAR

In our 23rd 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** 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:

\$9.75 per session per student if dropped off between 7:31 – 8:15 AM
 \$16.50 per session per student if dropped off between 7:00-7:30 AM

Afternoon Session:

\$18.25 per session from dismissal @ 2:40 PM – 4:00 PM
 \$29.50 per session per student from dismissal @ 2:40 – 4:01-6:00 PM

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

\$15.00 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. Registrations received after August 1 may be put on waitlist based on enrollment.

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: / /
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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:
	/ /