NORTH SHORE
BEFORE/AFTER
SCHOOL CHILD CARE
Est 2003

Michael Lynch, Executive Director
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REGISTRATION FORM
2022 - 2023 SCHOOL YEAR

In our 20th year, Sea Cliff, Glenwood Landing, and Glen Head Elementary School Cafeterias are sites for the Before/After School Enrichment 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 including Pottery & Jewelry Classes, Builders Club, Flag Football, Soccer, Baseball, Painting, Charity Events and Cooking Classes.

Each program is open from **7:00 AM until the start of school** @ 8:30 AM and **from dismissal at 2:40 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:
$8.00 per session per student if dropped off between 7:31 – 8:15 AM
$15.25 per session per student if dropped off between 7:00-7:30 AM

Afternoon Session:
$15.75 per session from dismissal @ 2:40 PM – 4:00 PM
$27.50 per session per student from dismissal @ 2:40 – 4:01-6:00 PM

Half Days of School, Parent/Teacher and Supt's Conference Days:
$13.25 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/Scan/Email it, along with the annual registration fee check per child (no sibling discount on registration fee), AND Health Attestation Form to NSbefore.after@gmail.com 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: _____	Mon PM _____	from dismissal until: _____
Tue AM _____	_____	Tue PM _____	until: _____
Wed AM _____	_____	Wed PM _____	until: _____
Thur AM _____	_____	Thur PM _____	until: _____
Fri AM _____	_____	Fri PM _____	until: _____

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DAY CARE ENROLLMENT

PHOTO OF CHILD (Optional)	Child's Full Name: Preferred Name/Nickname:	Date of Birth: / /	Gender:
	Child's Home Address:		
	Name of Person Enrolling Child:	Relationship to Child: ☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative _____ ☐ Other _____	

Phone Number(s) of Person Enrolling Child: ( ) - ☐ ok to text **Email Address:**	Address of Person Enrolling Child (if different than child):

EMERGENCY INFO

EMERGENCY CONTACT NAMES / ADDRESSES	Authorized to Pick Up Child	PRIMARY PHONE NUMBER	OTHER PHONE NUMBER / EMAIL
Primary Contact:	☐ Yes ☐ No	☐ ok to text	☐ ok to text
	☐ Yes ☐ No	☐ ok to text	☐ ok to text
	☐ Yes ☐ No	☐ ok to text	☐ 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: / /

OCFS-6040 (6/2020)

NEW YOK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD CARE EMPLOYEE, VOLUNTEER, PARENT, CHILD AND ESSENTIAL VISITORS HEALTH SCREENING ONE-TIME ATTESTATION

Before entering a child care program, employees, volunteers, parents, children and essential visitors ***must complete a health screening questionnaire daily. In addition, each employee, volunteer, parent, child and essential visitor must sign and submit this form to the program one time.*** Employees, volunteers, parents, children and essential visitors must answer all questions and take their temperature daily to confirm a body temperature lower than 100.0 degrees Fahrenheit. If anyone answers "Yes" to any of the questions below, they cannot enter the child care program. A parent or guardian is responsible for completing daily screening on behalf of their child(ren).

Self-Screening:

Below are the self-screening questions that employees, volunteers, parents, children and essential visitors are required to answer **daily**. If any of the answers to the below questions are "Yes," individuals **cannot** enter the program. If the answers are "No" to all the following questions, individuals may enter the program. If employees, volunteers, parents, children and essential visitors cannot take their temperature at home, but answer "No" to all other questions, they may report to the program to have their temperature taken on site.

1. Is your temperature higher than or equal to 100.0 degrees Fahrenheit?
2. Have you had any known contact with a person confirmed or suspected to have COVID-19 in the past 14 days?
3. Are you currently experiencing *ANY* of the following symptoms?
   - Cough (new or worsening)
   - Shortness of breath (new or worsening)
   - Trouble breathing (new or worsening)
   - Fever
   - Chills
   - Muscle pain (new or worsening)
   - Headache (new or worsening)
   - Sore throat (new or worsening)
   - New loss of taste
   - New loss of smell
4. Have you tested positive for COVID-19 through a diagnostic test in the past 14 days?

If you have answered "NO" to all questions, you have passed and may enter the program.

If you have answered "YES" to any question, you will not be allowed to enter the program.

Attestation: By signing this document, I agree that I will self-monitor these symptoms each day and report the outcome per the instructions above and will not enter any child care program if any of the above symptoms or conditions are present.

Signature	Date / /
Signature	Date / /

Note: *This document must be signed and returned to the program prior to entry. A signed copy needs to be provided only once. The child care program must retain a copy for their records.*