

## Summer Care Registration 2021

If not 6 by September 1, 2021, please use other form

**Child's Name:** \_\_\_\_\_ **Age (by 9/1/21):** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_

**Current School:** \_\_\_\_\_ **Current Grade:** PS5 KG 1 2 3 4 5 6 **Gender:** M F

\$65 Registration Fee Payment Method:	
X	
	<b>Check Attached</b>
	<b>Bill Current TADS Account</b>

Tuition Rates 20-21	
<b>4-5 Days</b>	<b>\$155/week</b>
<b>3 Days</b>	<b>\$115/week</b>
<b>1-2 Days</b>	<b>\$85/week</b>

**Enrollment:** Complete this Registration Form and email to [mclausen@ogknights.org](mailto:mclausen@ogknights.org), or turn in to your school administrative assistant by **March 22**. A separate Registration Form must be completed for each student in a family. **The student is not considered enrolled until the Registration Form is received and the \$65 non-refundable registration/activity fee per child is paid. Summer Care location is Holy Spirit Elementary.**

**Directions:** Check attendance weeks, circle the rate for the number of days attending, enter the weekly amount due, and circle the days of the week attending. *Field trips are typically Tuesdays and Thursdays.*

X	Week No. and Dates	4-5 Days	3 days	1-2 days	Total/Week	Pmt Due Date	Days Attending
	<b>1</b> (May 24–May 28)	\$155	\$115	\$85	\$	May 20 <sup>th</sup>	M T W R F
	<b>2</b> (June 1–4)*	\$155	\$115	\$85	\$	May 20 <sup>th</sup>	T W R F

X	Week No. and Dates	4-5 Days	3 days	1-2 days	Total/Week	Pmt Due Date	Days Attending
	<b>3</b> (June 7 –June 11)	\$155	\$115	\$85	\$	June 1 <sup>st</sup>	M T W R F
	<b>4</b> (June 14 –June 18)	\$155	\$115	\$85	\$	June 1 <sup>st</sup>	M T W R F

X	Week No. and Dates	4-5 Days	3 days	1-2 days	Total/Week	Pmt Due Date	Days Attending
	<b>5</b> (June 21 –June 25)	\$155	\$115	\$85	\$	June 15 <sup>th</sup>	M T W R F
	<b>6</b> (June 28 – July 2)	\$155	\$115	\$85	\$	June 15 <sup>th</sup>	M T W R F

X	Week No. and Dates	4-5 Days	3 days	1-2 days	Total/Week	Pmt Due Date	Days Attending
	<b>7</b> (July 6 –July 9)*	\$155	\$115	\$85	\$	July 1 <sup>st</sup>	T W R F
	<b>8</b> (July 12 –July 16)	\$155	\$115	\$85	\$	July 1 <sup>st</sup>	M T W R F

X	Week No. and Dates	4-5 Days	3 days	1-2 days	Total/Week	Pmt Due Date	Days Attending
	<b>9</b> (July 19 –July 23)	\$155	\$115	\$85	\$	July 15 <sup>th</sup>	M T W R F
	<b>10</b> (July 26 –July 30)	\$155	\$115	\$85	\$	July 15 <sup>th</sup>	M T W R F

X	Week No. and Dates	4-5 Days	3 days	1-2 days	Total/Week	Pmt Due Date	Days Attending
	<b>11</b> (Aug 2 –Aug 6)	\$155	\$115	\$85	\$	July 25 <sup>th</sup>	M T W R F

\*There is NO SUMMER CARE scheduled for Monday, May 31<sup>st</sup> (Memorial Day), Monday, July 5<sup>th</sup> (for Independence Day), or the week of Aug 9-13.

**Billing and Program Notes:**

- All 2020-2021 school year tuition must be paid in full prior to attendance in the Summer Care Program.
- Summer Care fees are payable by ACH or credit card. If you do not currently have a TADS account set up with automatic payments for the 20-21 school year, you will be contacted with instructions. All families must have automatic payment information on file.
- Morning snack, lunch, and afternoon snack are included in the program. No fast food lunches or delivered meals.
- There is a \$1 per minute/per child late fee for children who are picked up after the 6 PM closing time.
- City pool swimming passes are required for any child wishing to participate in Summer Care swimming activities.
- Special activities may require fees (calendars will reflect activities/cost/permission, etc.)
- ALL STUDENTS ATTENDING THE SUMMER CARE PROGRAM MUST BE FULLY POTTY-TRAINED!

**Refund Policy:**

Billing changes will be accepted only if notification is made in writing 15 days prior to the payment due date. Requests must be made in writing to [jgaspar@ogknights.org](mailto:jgaspar@ogknights.org). Please also notify Mary Lou Clausen ([mclausen@ogknights.org](mailto:mclausen@ogknights.org)) of any schedule changes. No refunds will be issued for any requests that do not follow these guidelines.

**PARENT/GUARDIAN SIGNATURE REQUIRED:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Printed Name: \_\_\_\_\_ Email: \_\_\_\_\_ Phone: \_\_\_\_\_

(Date Received \_\_\_\_\_ Check # \_\_\_\_\_)

# Bishop O’Gorman Catholic Schools Summer Care Program Emergency Contact Card

\*\*Please complete one Emergency Contact Card form per family.\*\*

**Please print all information.** This form will be used to contact you in case of an emergency. Please be sure all information is correct and complete. This information will be kept confidential.

**FAMILY NAME:** \_\_\_\_\_

**Child #1:** \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Current Grade: \_\_\_\_\_

**Child #2:** \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Current Grade: \_\_\_\_\_

**Child #3:** \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Current Grade: \_\_\_\_\_

**Child #4:** \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Current Grade: \_\_\_\_\_

**Father’s Name:** \_\_\_\_\_

Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Home Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Mother’s Name:** \_\_\_\_\_

Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Home Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Only the following persons are authorized to pick up my child:**

**Name:** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**If parent/guardian cannot be reached in case of emergency, I authorize the Summer Care staff and the following people to grant permission for treatment:**

1) **Name:** \_\_\_\_\_ Phone: \_\_\_\_\_  
Relationship to Child: \_\_\_\_\_

2) **Name:** \_\_\_\_\_ Phone: \_\_\_\_\_  
Relationship to Child: \_\_\_\_\_

3) **Physician’s Name:** \_\_\_\_\_ Phone: \_\_\_\_\_  
Hospital Preference: \_\_\_\_\_ Phone: \_\_\_\_\_

**Immunization Records:**

My child’s immunization records are on file at a Bishop O’Gorman Catholic Schools’ school.

I have attached my child’s immunizations records.

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*\*You must notify the school if any of the above information changes.\**

# Bishop O’Gorman Summer Care Program Health Emergency Card

**\*\* Please complete one Health Emergency Card per family. \*\***

**Please print all information.** In case of summer care-related accidents, illness or summer care dismissal communication, please complete.

**FAMILY NAME:** \_\_\_\_\_

**Child #1:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_ **Current Grade:** \_\_\_\_\_

**Ethnicity of Student:**  Hispanic/Latino  Non-Hispanic/Latino **Race of Student (Mark all that apply):**  
 American Indian or Alaska Native  Asian  Black or African American  Native Hawaiian or Other Pacific Islander  White

**Child #2:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_ **Current Grade:** \_\_\_\_\_

**Ethnicity of Student:**  Hispanic/Latino  Non-Hispanic/Latino **Race of Student (Mark all that apply):**  
 American Indian or Alaska Native  Asian  Black or African American  Native Hawaiian or Other Pacific Islander  White

**Child #3:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_ **Current Grade:** \_\_\_\_\_

**Ethnicity of Student:**  Hispanic/Latino  Non-Hispanic/Latino **Race of Student (Mark all that apply):**  
 American Indian or Alaska Native  Asian  Black or African American  Native Hawaiian or Other Pacific Islander  White

**Child #4:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_ **Current Grade:** \_\_\_\_\_

**Ethnicity of Student:**  Hispanic/Latino  Non-Hispanic/Latino **Race of Student (Mark all that apply):**  
 American Indian or Alaska Native  Asian  Black or African American  Native Hawaiian or Other Pacific Islander  White

**Hospital Preference:** **Avera McKennan / Sanford**

**Physician First and Last Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Medical Conditions, Allergies, or Medications (please state clearly which child):**

**If my child needs the following, I authorize summer care personnel to administer (check all that apply):**

**Acetaminophen (Tylenol)**  **Ibuprofen (Advil/Motrin)**

Administration of “over the counter” medication will be at the discretion of the appointed personnel, consistent with the recommended dose for age as defined on package guidelines.

**Medical Release:**

*I hereby consent to any medical services that may be required while my child is under the supervision of an employee of the Bishop O’Gorman Catholic Schools Summer Care program and hereby appoint a Summer Care employee to act on my behalf in securing necessary medical services from any duly licensed physician or medical emergency provider. Responsibility for payment of ambulance, physician and/or hospital is that of the parent or guardian.*

**Yes, I agree to the above medical release.**

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

***\*You must notify the school if any of the above information changes.\****