

# BEFORE SCHOOL PROGRAM

Child's Name \_\_\_\_\_ Grade \_\_\_\_\_

Program Choice- Please indicate your choice  
Before School Program hours are 7:00 – 8:20 am

MONDAY

TUESDAY

WEDNESDAY

THURSDAY

FRIDAY

**Costs:**

1 – 3 days with contract	\$8.00/per day
4 – 5 days with contract	\$7.00/per day
Drop in days - No contract	\$10.00/per day (pre-paid)

Total number of days \_\_\_\_\_ Total Cost \_\_\_\_\_

START DATE \_\_\_\_\_

## PAYMENT INFORMATION

There is an initial enrollment fee of \$10.00 per family due at time of registration. All fees are paid on a monthly by check (checks payable to Suffield Public Schools) Money order or cash, all payments are **due on the first of each the month.**

Primary Billing Party (Mother/Father) \_\_\_\_\_

Daytime phone \_\_\_\_\_

Initial Enrollment fee to be paid with registration	Per family	\$ <u>10.00</u>
<b>Sibling Discount – 15% off second child's tuition – NEW</b>		\$ _____
	Monthly Program Fee	\$ _____
	<b>TOTAL DUE</b>	\$ _____



## REGISTRATION 2023 – 2024 School Year

### Child Information

Child's name \_\_\_\_\_ Grade \_\_\_\_\_  
Home Address \_\_\_\_\_ Birth Date \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
Home Telephone \_\_\_\_\_ Email Address \_\_\_\_\_

NO       YES    The Before/After-School Program has permission to photograph  
My child to be used for projects, newspaper articles, etc.

### Parent/Guardian Information

**Mother's name** \_\_\_\_\_  
Home Address \_\_\_\_\_  
Home phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Business Address \_\_\_\_\_

**Father's name** \_\_\_\_\_

Home Address \_\_\_\_\_  
Home phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Business Address \_\_\_\_\_

**Other Contact** \_\_\_\_\_ relationship to student \_\_\_\_\_

Home Address \_\_\_\_\_  
Home phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Business Address \_\_\_\_\_

### Medical:

***In case of emergency, which of the parent/guardians should we contact first?*** \_\_\_\_\_

Doctor \_\_\_\_\_ phone (    ) \_\_\_\_\_

Dentist \_\_\_\_\_ phone (    ) \_\_\_\_\_

Preferred Hospital \_\_\_\_\_

Medical concerns/allergies: \_\_\_\_\_

***[ ] Yes, I give permission to the Before/After-School staff to administer First Aid in case of injury. In the event my child needs emergency attention and I cannot be contacted, I give the Before/After-School staff permission to authorize medical treatment for my child.***



### **Parent/Guardian Agreement**

*I understand that the Registration Fees are non-refundable, non-transferable and for administration purposes only. I will give two weeks' notice in writing via email, of any changes in my child's schedule (including withdrawal from the Before-After School Program). I will also be responsible for full payment of these two weeks of before/after school care. The Before-After School Program assumes responsibility for my child's well-being during the time he/she attends the program and the parent is responsible for all costs of any medical treatment and care. The information on this Registration Form is complete and accurate and I will promptly notify the Before-After School Program of any changes. **I will notify the Program Coordinator directly** if my child will be absent from the program. I understand that my child needs to follow the same rules for the Suffield Public School system while attending the Before-After School Program. If a verbal warning is given to any student/family for inappropriate behavior or language then my child could be terminated from the program at any point thereafter. Dismissal of students due to behaviors issues will be determined by the Program Coordinator.*

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*Parent/Guardian Signature*

*My signature acknowledges my understanding and consent to the above agreement.*

*Date*

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