EVANSTON/SKOKIE
SCHOOL DISTRICT 65

□ Regwerks □ Mealsheet ◊ PowerSchool (course) □ Class List
2024 SACC Summer Camp Coversheet

Date Steps Completed

	Received (in person/email/fax)
	Reviewed
	To Fees

Grade: _____ **Start Date: _____**

Last:_____ **District 65 ID: _____**

First: _____ ◊ new sibling _____

Middle: _____ □ returning siblings _____

Registered in District 65 Schools (Y/N)? □ Yes @D65 Student Registration Date: _____

Every Child, Everyday
Whatever it takes

Session Status *Fees subject to change* revised 1/5/24

Check Full Day or Half Day	Check Session	Check Fee	Check Subsidy	Summer Camp Youth Size T-Shirt $10 (more than one please provide quantiy)
□ Full Day 7 AM - 6 PM	□ Session I	□ $900 Each Session	□ Yes	□ Small __
□ Half Day AM 7 AM - 1 PM	□ Session II	□ $750 Each Session	□ No	□ Medium __
□ Half Day PM 12 PM - 6 PM	□ Session I & II	□ $0 (Subsidy Monthly Rate Applies)	Approved DHS With D65 Listed as Provider Must Accopany Enrollment Forms	□ Large __
				□ Xlarge __

There is a non-refundable $50 registration fee per each child enrolled or children enrolled not already enrolled in the SACC Summer Program. **IF ENROLLING IN BOTH SESSIONS I & II YOU WILL BE CHARGED PER EACH ENROLLED SESSION.**

A $160 per child deposit plus registration fee is due at enrollment.
Summer Camp Session I Payment is due by April 15th and Session II by May 15th.

Subsidy families must apply/qualify through AFC/DHS and have their approval list D65 as a provider prior to enrollment in the summer camp prograı

Who is responsible for payment of fees? Print Name:_____ Day Phone: _____

PEFERRED EMAIL: _____

Parent Signature _____ Date: _____

Preferred email for communications (Please print clearly) : _____

Evanston/Skokie School District 65
www.district65.net
Forward to Excellence

Handbook Provided ◯ Parent Pkt Recd◯

District 65 School Age Childcare Summer Camp Application 2024 - 25

	Parent A	Parent B
Parent Name:		
Best Contact Number (cell, home, work):		
Organization/Occupation:		
Mailing Address		
Preferred email		
Working hours		

Child's Name as listed on birth certifcate	Scheduled Start Date	Birthdate	Age	as: as:	Current School Name	Child in Special Ed?	Entering Grade	Select Session
Last:				□ M □ Non - Binary □ F		□ Yes or □ No	□ K □ 1 □ 2 □ 3 □ 4 □ 5 No 6th Grade	□ **Full Time** □ **Part Time AM** □ **Part TimePAM**
First:					School Attended Last Yr	□ Phs or □ Beh		
Middle:	**Returned date**:					□ Rice □ Park □ MS		
District 65 ID #:						1-1 IEP? Y □ or N □		

Child's Name as listed on birth certifcate	Scheduled Start Date	Birthdate	Age	as: as:	Current School Name	Child in Special Ed?	Entering Grade	Select Session
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First:					School Attended Last Yr	□ Phs or □ Beh		
Middle:	**Returned date:**					□ Rice □ Park □ MS		
District 65 ID #:						1-1 IEP? □ Y or □ N		

By signing below you are also agreeing that: In case of emergency, when parent or family physician cannot be contacted.
I give District 65 Child Care personnel permission to take whatever action is deemed necessary to ensure my child's health and safety. I will accept responsibility for any expenses incurred.

Parent Signature:_____ **rev. 2/6/23** Print Name:_____ Date: _____

SACC SUMMER CAMP PAYMENT AGREEMENT 2024

Please ***check mark*** applicable section, fill out the information as needed, and sign the agreement below:

1. ____ I am registering by FAX/MAIL and am **paying in full** of check (enclosed) or Credit Card (Information filled out below)
2. ____ I am registering by FAX/MAIL and **am only paying a $160.00 deposit** (t-shirt fee included) plus registration fee if applicable (new registering family: Check (enclosed) or Credit Card (Information filled out below). I want the remaining camp balance to be auto debited on payment dates as set forth below.

Please ***initial*** below:

a. **____ I authorize Evanston/Skokie School District 65 to auto-debit the remaining camp balance in 2 equal amounts. The first half on April 15, 2024, and the second half on May 15, 2024, using the following:**

Please check size Camp T-shirt Size Cost $10.00 included with deposit above: ☐ **Youth Small** ☐ **Youth Medium** ☐ **Youth Large** ☐ Y X-Large

Credit Card

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name: _____
Account Number: _____
Exp. Date: _____
3 Digit Security Code: _____

Agreement:

1. **I understand that I am responsible to notify the Evanston/Skokie School District 65 immediately if credit card information changes. _____ Initial Required**
2. **I understand that these financial arrangements will remain in effect until**
   a. **The total amount due is collected by Evanston/Skokie School District 65.**
   b. **I have requested in writing a cancellation of the program and have paid all current fees or**
   c. **Evanston/Skokie School District65 sends me a notice of termination of this agreement.**
   d. **Auto payment will be applied in accordance with the summer camp payment agreement initialed above (first half due April 15th & second half due May 15th)**
3. **I understand that any declined payment will incur a $25.00 service fee. _____ Initial Required**
4. **Childcare Care cancellation must be made in writing by following the refund policy information provided to you below. Cancellations made after start of camp will not be eligible for a refund of any kind._____ Initials Required**

SIGNATURE: _____ DATE _____

School Age Child Care Summer Camp Late Pick-Up Fee Disclosure

* ☐ By checking this box I understand:

The School Age Child Care Summer Camp Program closes promptly at 6:00 p.m. during summer without exception. A fee is charged for late pick-up which will be billed through the D65 Business Office and will appear on each child's financial summer camp statement. **The clock time at the childcare site** is considered the **official time.** You will be notified on the day of the late pick-up of the cost you will be charged. Payment will be billed and processed accordingly to the card on file if your student is picked up after 6 PM closing. DHS families receiving childcare benefits will also incur the late pickup charge as the state will not cover any additional cost after closing time.

Example of Child Late Fees:

- 1-15 minutes = $25.00
- 16-30 minutes = $50.00
- 30-45 minutes = $75.00
- 46-60 minutes = $100.00

Late fees begin at 6:01 p.m. SACC staff employees are required to report all families that are late to district office Fees Coordinator. Staff should not be asked to overlook late pick-up at any time. Any parent that does not agree with the late pickup fee should contact **Clara Estrella (SACC Fees Coordinator)** at either **847-859-8015** or estrellac@district65.net

Camp Refund Policy

SACC SUMMER Camp Refund Policy 2024

Camp Session Start Date	Refund Deadline to receive 100%	Refund Deadline to receive 75%	Refund Deadline to receive 50%	Refund Deadline to receive 25%	Non-refundable Deadline
	On or Before	On or Before	On or Before	On or Before	On or Before
6/10/2024 Session I	26-May	2-Jun	5-Jun	12-Jun	13-Jun
7/8/2024, Session II	23-Jun	30-Jun	3-Jul	10-Jul	11-Jul

To process your request, we ask you to forward your request via email to Clara Estrella SACC Fees Coordinator at estrellac@district65.net. Any credit due from a refund will be first applied to any household balance that exists. All refunds will be processed within 24 to 48 hours of receipt if not sooner of the original request.

Thank you for choosing Evanston/Skokie School District 65 Child Care. We are looking forward to having an educational and fun-filled summer with your child(ren).

Feel free to contact Ms. Charlotte Carter School Age Manager of Extended Care at (847) 859-8078 or Mr. Steven Frost Asst School Age Child Care Coordinator at (847) 859-8118 with program business. Please contact Clara Estrella School Age Child Care Fees Coordinator at (847) 859-8015 with questions regarding your childcare account and fees.

Sincerely,

School Age Child Care Management

School Age Child Care
Evanston/Skokie School District 65
1500 McDaniel Ave.
Evanston, IL 60201
Charlotte Carter 847-859-8078
Steven Frost 847-859-8118

EVANSTON/SKOKIE SCHOOL DISTRICT 65
Every Child, Every Day, Whatever it Takes

GETTING TO KNOW YOU

CHILD CARE SITE:

NAME _____ AGE ___ NUMBER OF SIBLINGS: _____

Child's favorite toy/game/activity
_____

What is the best way to get acquainted with your child?
_____

How does your child show his/her feelings when angry or happy?
_____

If upset, what is the best way to calm and/or comfort your child?
_____

In general how is discipline handled at home?
_____

Do you have any suggestions/hints for our staff that may help us be more successful with your child(ren)? _____

Has your child participated in another Child Care Program? Yes □ No □

Medical History
Does your child(ren) have any medical conditions ◯ Yes ◯ No
If yes, please explain & give pertinent information (medications etc)
_____

Does your child(ren) have any allergies or sensitivities? Yes ◯ No ◯
If yes, please explain & give pertinent information (medications, Epi-Pen etc)
_____

_____ _____
Parent Signature **Date**

School Age Child Care
Evanston/Skokie School District 65
1500 McDaniel Ave.
Evanston, IL 60201
Charlotte Carter 847-859-8078
Steven Frost 847-859-8118

▪

School Age Child Care Program

Parent Pick-up Release Form

_____ _____
Child's name **Site**

Note: Children will not be released to minors. The pick-up person must be at least 18 years old with a valid I.D. Please complete all the information requested in the space below.

I GIVE PERMISSION FOR THE FOLLOWING ADULTS TO PICK UP MY CHILD(REN):

1. _____ _____ _____
Name **Address** **Cell/Work#**

2. _____ _____ _____
Name **Address** **Cell/Work#**

3. _____ _____ _____
Name **Address** **Cell/Work #**

Is your child under a court order of protection? ____ **Yes** ____ **No**
If yes, a copy of the court document must be provided/attached.

_____ _____
Parent Signature **Date**
Charlotte Carter
School Age Child Care Coordinator

School Age Child Care
Evanston/Skokie School District 65
1500 McDaniel Ave.
Evanston, IL 60201
Charlotte Carter 847-859-8078
Steven Frost 847-859-8118

EVANSTON/SKOKIE SCHOOL DISTRICT 65
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CHECKLIST

I understand that due to state licensing requirements; Child Care (SACC) staff cannot accept sack lunches as a substitute for providing meals. I shall provide written confirmation from my doctor if my child requires a substitution. **Initials** _____

I have received the DCFS Summary of Licensing Standards for Day Care Centers. **Initials** _____

I have reviewed online at www.district65.net Rules for Student Behavior and School Discipline and the SACC Guidance and Discipline policy. I will ensure my child(ren) fully understands how this information pertains to them while in our care. **Initials** _____

I have reviewed and understand the SACC late pick-up process and policy. **Initials** _____

I grant permission for my child(ren) to participate in SACC field trips and related activities. **Initials** _____

Additionally, I grant permission for my child(ren) to be photographed/videotaped and interviewed while participating in SACC activities or on field trips. **Initials** _____

My signature confirms I have read the statements above in addition to reviewing the current SACC Parent Handbook (online and/or hard copy).

_____ _____
Signature of Parent/Guardian **Date**

Evanston / Skokie
School District 65 **Health Services Department**

Dear Parent/Guardian:

If it is necessary for your child to take medication at school, you must read and complete the following form. In accordance with the Recommended Guidelines for Medication Administration in Schools through the Illinois Department of Human Services and the Illinois State Board of Education, all medications administered in school, including non-prescription drugs, shall be prescribed by a licensed prescriber. A written order for prescription and non-prescription medications must be obtained from the students' licensed prescriber along with a written request from the parents/guardian requesting that medication be given and/or self-administered during school hours.

Medicine can only be given by school personnel if ordered by a physician or qualified provider. The written order must include the licensed prescribers name, signature, stamp and date. All prescription medication must be in its original packaging with the prescription label attached. Over-the-counter medication must be in a sealed bottle with the manufacturer's original label with the ingredients listed and the student's name affixed to the container. on the packaging. Students who need to carry and use their epinephrine, insulin or asthma medication must have signed orders under a qualifying plan from both the physician and the parent/guardian.

PARENTAL MEDICATION REQUEST

I HEREBY CONFIRM MY PRIMARY RESPONSIBILITY TO ADMINISTER MEDICATION TO MY CHILD. HOWEVER, IF MY CHILD MUST RECEIVE MEDICATION WHILE IN SCHOOL, I AUTHORIZE SCHOOL DISTRICT 65 AND ITS EMPLOYEES TO ADMINISTER LAWFULLY PRESCRIBED MEDICATION TO MY CHILD. I ACKNOWLEDGE THAT IT MAY BE NECESSARY THAT THE ADMINISTRATION OF MEDICATIONS TO MY CHILD BE PERFORMED BY A HEALTH CLERK OR OTHER INDIVIDUAL WHO IS NOT A CERTIFIED SCHOOL NURSE AND SPECIFICALLY CONSENT TO SUCH PRACTICES. I FURTHER ACKNOWLEDGE AND AGREE THAT, WHEN THE LAWFULLY PRESCRIBED MEDICATION IS SO ADMINISTERED OR ATTEMPTED TO BE ADMINISTERED, I WAIVE ANY CLAIMS I MIGHT HAVE AGAINST THE SCHOOL DISTRICT AND ITS EMPLOYEES AND AGENTS ARISING OUT OF THE ADMINISTRATION OF SAID MEDICATION. IN ADDITION, I AGREE TO HOLD HARMLESS AND INDEMNIFY THE SCHOOL DISTRICT AND ITS EMPLOYEES FROM AND AGAINST ANY AND ALL CLAIMS, DAMAGES, CAUSES OF ACTION OR INJURIES INCURRED OR RESULTING FROM THE ADMINISTRATION OR ATTEMPTS AT ADMINISTRATION OF SAID MEDICATION.

I WILL NOTIFY THE SCHOOL OF ANY CHANGE IN MEDICATION OR DOSAGE AND WILL SEND THE SCHOOL A WRITTEN ORDER FROM THE DOCTOR WHEN A CHANGE IS NECESSARY.

I HEREBY REQUEST THAT SCHOOL PERSONNEL ADMINISTER THE FOLLOWING MEDICATION TO:

_____
NAME OF CHILD

_____	_____	_____	_____
MEDICATION	**DOSAGE**	**TIME**	**START & STOP DATES**

_____ _____
PARENT'S/GUARDIAN'S SIGNATURE **DATE**

_____ _____ _____
PHYSICIAN'S SIGNATURE **DATE** **TELEPHONE NUMBER**

Prescribers Office Stamp

Rev. (9/22)

CFS 581
Rev. 12/2000

State of Illinois
Illinois Department of Children and Family Services

VERIFICATION OF RECEIPT

I/WE, _____
Please Print Name(s)

parent(s) of _____, hereby certify that I/we have
Name(s) of Child(ren)

received a copy of a summary of licensing standards printed by the Illinois Department of Children and Family Services.

_____ _____
Signature of Parent Date

_____ _____
Signature of Parent Date

THIS COMPLETED FORM IS TO BE PLACED IN EACH CHILD'S FILE AT THE DAY CARE FACILITY.