CHRISTOPHER J. TRANBERG, PH.D.
Superintendent of Schools
ALLISON K. MORAN
Assistant Superintendent of Schools

BLAIZE LEVITAN
Chief Operating Officer

BRANFORD PUBLIC SCHOOLS
FAMILY RESOURCE CENTER
12 Melrose Avenue, Branford CT 06405
203-481-5066 • Fax 203-481-7160

School-Aged Child Care (SACC) Application and Release Form - CONFIDENTIAL

Today's Date: _____ Start Date: _____

Child 1 Name:_____ Age: _____ Date of Birth: _____
School: _____ Gender: _____ Grade: _____

Child 2 Name:_____ Age: _____ Date of Birth: _____
School: _____ Gender: _____ Grade: _____
Child(ren) resides with (specify name and relationship): _____

Parent/Guardian 1 Name:_____ Relationship to Child: _____
Home/Cell Number(s): _____ Home Address: _____
Marital Status: ☐ ☐ Married ☐ Divorced ☐ Separated Single
Home Email**:** _____ Occupation: _____ Name of Employer: _____
Employer Phone Number: _____ Employer Address: _____

Parent/Guardian 2 Name:_____ Relationship to Child: _____
Home/Cell Number(s): _____ Home Address: _____
Marital Status: ☐ ☐ Married ☐ Divorced ☐ Separated Single
Home Email**:** _____ Occupation: _____ Name of Employer: _____
Employer Phone Number: _____ Employer Address: _____

Emergency Information
In case I am unavailable or in an emergency, my child may be released to the following people (photo ID required):

1. Name: _____ Phone: _____ Relationship to Child:_____
2. Name: _____ Phone: _____ Relationship to Child _____
3. Name: _____ Phone: _____ Relationship to Child:_____

DO NOT release my child(ren) to the following people:
Name: _____Name:_____

Note: It is legal for either parent or legal guardian to pick up a child unless we have a copy of a court order restricting visitation.

NOTE: Your application will not be processed until all paperwork is filled out, including your child's most recent health form. The form must be completed by a healthcare provider Before attending the program, all necessary fees must be paid in full**.**

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Parent/Guardian Release Agreements and Permissions

By signing at the bottom of this page, you are agreeing to all of the statements below.

For Students with Disabilities Under an IEP:
To help ensure the appropriate programming for your child, the Director of Early Childhood would like permission to share your child's IEP with the FRC staff for educational planning purposes. I give permission for the Director of Early Childhood to share my child's IEP with the FRC staff.

YES _____ NO _____

Consultation with School Staff:
As the parent/legal guardian of _____, I, _____, give my permission for the Director of Early Childhood and/or the Program Coordinator to consult with school staff regarding my child during this school year. I understand that the confidential sharing of any medical, academic, or social-emotional concerns may be necessary to ensure that SACC staff can more effectively support my child.

Media:
At times, we take pictures of the children in the program, and the media may be present at events. Do you approve of your child being photographed and/or videotaped? We often post pictures of classroom activities on the district website.

Inclusion in Photographs:	***Inclusion in Videos:***	***Posting on District Website:***
YES _____ NO _____	YES _____ NO _____	YES _____ NO _____

Walking off School Grounds
Occasionally, we take "walking" field trips to locations that are nearby:, the local neighborhood, etc. Weather is often a determining factor and the decision to go is made on that particular day. Do you give permission for your child to participate?

YES _____ NO _____

_____ _____
Parent/Guardian Signature Date

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SACC Health Emergency Form

Child 1 Name:_____ Age: _____ Date of Birth: _____

Allergies/Medical Conditions: _____

Medication Required at SACC? ☐ YES* ☐ NO (*If yes, Authorization for Administration of Medication form required)

Required Supports or Accommodations: _____

Child 2 Name:_____ Age: _____ Date of Birth: _____

Allergies/Medical Conditions: _____

Medication Required at SACC? ☐ YES* ☐ NO (*If yes, Authorization for Administration of Medication form required)

Required Supports or Accommodations: _____

Parent/Guardian 1 Name:_____ Daytime Phone Number: _____

Parent/Guardian 2 Name:_____ Daytime Phone Number: _____

Child's Pediatrician: _____ Phone Number: _____

Child's Dentist: _____ Phone Number: _____

Preferred Hospital: _____

In case parents/guardians are unavailable during an emergency, who should be contacted?

1. Name: _____ Phone: _____ Relationship to Child:_____

2. Name: _____ _ Phone: _____Relationship toChild:_____

NOTE: If your child(ren) is mentioned in a custody agreement or divorce settlement that will impact their SACC pick-up or drop-off, please provide us with a copy of that documentation. Otherwise, both parents/guardians will be.

_____ _____

Parent/Guardian Signature Date

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Permission to Treat

I, _____ give permission to the Certified First Aid Child Care Staff to treat my child, _____, if necessary. I authorize the Child Care Staff to consent to emergency medical treatment (under advice of a CT licensed physician) for my child, _____, when the need for such treatment is immediate and when efforts to contact me are unsuccessful. My child will be transported to the nearest emergency facility. I understand that any expenses incurred throughout transportation and treatment are my responsibility.

_____ _____

Parent/Guardian Signature Date

Policies and Procedures Acknowledgement

I have received, read, and understand the policies in the Family Handbook (also available on the website). I understand that it is my responsibility to know the policies in this handbook, and to review them when necessary. If I have questions, I understand that it is my responsibility to ask for clarification prior to signing this document.

In addition, please note that no electronic devices, including cell phones, can be brought to camp. Please note: SACC staff and the SACC program are not responsible for lost, stolen, or damaged items that a child brings to camp.

By signing below, I am indicating that I agree to follow BPS SACC policies, and I accept the statements above.

_____ _____

Parent/Guardian Signature **Date**

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Monthly Hours and Fees

PRE-K SACC HOURS 7:30 - 8:55 AM / 3:25 - 5:30 PM

Number of Days	Before School (7:30-8:55 am)	After School (3:25-5:30 pm)	Both AM and PM
5	$200	$325	$475
3	$135	$215	$315

KINDERGARTEN-GRADE 6 SACC HOURS 7:00 - 8:55 AM / 3:25 - 6:00 PM

Number of Days	Before School (7:00-8:55 am)	After School (3:25-6:00 pm)	Both AM and PM
5	$285	$405	$620
3	$190	$270	$415

10% Discount applied for Military Families (with valid Military ID), District employees and a second/third child enrolled.

Please list ALL household members and their relationship to your child and their age:

Name	Gender	Relationship to Child	DOB	School

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Financial Agreement

Today's Date: _____ Requested Start Date: _____ School: _____

I am requesting enrollment for my child/ren, _____ in:

Before School: _____ **After School: _____** **Both: _____**

Days (check all that apply): **M _____** **T _____** **W _____** **TH _____** **F _____**

(The 3-day option must remain consistent to ensure appropriate staffing**. Rotating schedules are not permitted.)**

I understand my **monthly** tuition will be $ _____. Payment is due by the 1st of each month, regardless of date invoiced. If payment is not received by the 10th of the month, a late fee of $30 will be charged to my account. If payment is not received by the end of that billing cycle and my account becomes delinquent, my child/ren will not be allowed to return to the program until the past due balance is paid in full. Failure to keep my account current will result in suspension from the program.

I understand that I am responsible for the tuition payment regardless of my child's absence from the program. I am aware that I will be charged a late fee of $10 for the first 5 minutes or any part thereof, and $1 every minute thereafter that my child remains in the program beyond the scheduled closing time. I understand that billing is created for family accounts and our financial department will not bill individuals separately, payments will be applied to the current amount due.

I understand for billing purposes, that 2 weeks notice must be given of any program change and will go into effect the 1st of the following month. I understand that **payment must be made in the form of check or money order only, made payable to: SACC**

The registration fee ($50 - individual / $75 - family) and the first month's tuition are **non-refundable and non-transferrable**. They are due at the time of enrollment. **We are unable to issue refunds.**

By signing below, I acknowledge that I understand the financial obligations required in order for my child to participate in the SACC program.

_____ _____

Parent/Guardian Signature Date

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SACC CHECKLIST

Please use the checklist below to ensure your application is complete before returning to the main office.

_____ SACC APPLICATION/RELEASE FORM

_____ PARENT RELEASE/PERMISSIONS

_____ HEALTH EMERGENCY FORM

_____ PERMISSION TO TREAT/ POLICIES AND PROCEDURES SIGN OFF

_____ PARENT FINANCIAL AGREEMENT

_____ HEALTH ASSESSMENT FORM (SUPPLIED BY HEALTHCARE PROVIDER)

_____ AUTHORIZATION TO ADMINISTER MEDS (SUPPLIED BY HEALTHCARE PROVIDER)

_____ REGISTRATION FEE and FIRST MONTH'S TUITION
($50/individual, $75/family) Check or Money Order ONLY - NO CASH

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