Reg Fee $_____
Rec'd_____
CK #_____

GREEN TOWNSHIP SCHOOL DISTRICT
CHILD CARE REGISTRATION

(A $25.00 per child non-refundable registration fee must accompany registration)

GENERAL INFORMATION:

Child's Name:_____ Date of Birth:_____

Parent's Name:_____ Phone:_____

Mailing Address:_____ Grade/Teacher:_____

City, Zip Code _____ Email address_____

EMERGENCY INFORMATION:

Parent/Guardian #1 Name/Employer:_____ Phone:_____

Parent/Guardian #2 Name/Employer:_____ Phone:_____

*Emergency Contact #1 _____ Phone:_____

*Emergency Contact #2_____ Phone:_____

*Emergency Contact #3_____ Phone:_____

*Emergency Contact #4_____ Phone:_____

*Should be an adult living locally who can assume responsibility for your child/children.

*Children may attend the Childcare Program on the days they are physically at school.

Daily rate of $5.00 a day for before care.
Daily rate of $20.00 a day for after care, additional siblings will be charged at $10.00 a day each

My child(ren) will be attending ____Before Care ____ After Care ____ Both

Families will be billed for the days they attend at the end of each month, with payment due no later than the 15th of the following month.

SIGNATURES: I hereby understand agree to the fees and regulations attached to this registration form and presented in our Child Care Manual (copy available on line or upon request.)

_____ _____
Parent/Guardian Date

GREEN TOWNSHIP SCHOOL DISTRICT

CHILD CARE PROGRAM

HEALTH HISTORY

Student Name:_____

Grade: _____

DOB: _____

Please provide as much information in this section as possible.

Present Medical Problems: _____

_____

Special care required:_____

Any known **Allergies**:_____

Asthma:_____

Medicine taken regularly:_____

Chronic or Recurring Illnesses: _____

Epi-Pen and Inhalers must be provided by the Parent/Guardian.

Has your Doctor certified that your child can self-administer his/her inhaler and/or Epi-Pen?
Yes:____ No: _____

A nurse is not available for the AfterCare program.

The Child Care Staff will NOT administer medications, including over the counter medications.

Family Physician:_____

Phone:_____

_____ _____

Parent/Guardian Date