

(Note: This packet contains forms for up to two children to register)

• Student Name (#1): _____ Grade: _____ Date of Birth: _____

School Attending: _____ Home Phone: _____ Start Date: _____

Early Morning Program _____ (check if needed) Days Needed: M Tu W Th F (circle days)	After School Program _____ (check if needed) Days Needed: M Tu W Th F (circle days)
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• Student Name (#2): _____ Grade: _____ Date of Birth: _____

School Attending: _____ Home Phone: _____ Start Date: _____

Early Morning Program _____ (check if needed) Days Needed: M Tu W Th F (circle days)	After School Program _____ (check if needed) Days Needed: M Tu W Th F (circle days)
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Name of Both Parent(s)/Guardian(s): _____
(first & last)

Home Address: _____

EMERGENCY CONTACT INFORMATION

Parent/Guardian Place of Employment:

Mother/Guardian: _____
(place of employment)

Work Phone: _____ Cell Phone: _____

Father/Guardian: _____
(place of employment)

Work Phone: _____ Cell Phone: _____

Student's Physician: _____ Phone: _____

I GIVE PERMISSION FOR MY CHILD TO BE PICKED UP BY ANY OF THE PEOPLE LISTED BELOW (NON-PARENTAL)

1. Name: _____	Relation to Student: _____	Phone: _____
2. Name: _____	Relation to Student: _____	Phone: _____
3. Name: _____	Relation to Student: _____	Phone: _____

Signature: _____ Date signed: _____

EASTERN SUFFOLK BOCES
EXTENDED DAY ENRICHMENT PROGRAM/EDUCATIONAL SUPPORT SERVICES
MEDICAL INFORMATION FORM

(Note: please use one medical page for each child)

A. Student Name (#1): _____ Date of Birth: _____

Male () Female ()

Home Address: _____

Home Phone: _____ Cell Phone _____

Email Address (please print): _____

B. Health History (list month and year if student had illness):

Ear Infection -	Mumps -	Rheumatic Fever -	Asthma -
Poison Ivy -	Hay Fever -	Measles -	Convulsions -
Insect Stings -	Chicken Pox -	Diabetes -	German Measles -

Any allergies (foods, drugs, plants, insects, other?) _____

Please explain: _____

Operations or serious injuries (type and date): _____

Chronic or recurring illness: _____ Other diseases: _____

Does your child wear glasses? _____ Does he/she wear them all the time? _____ Contact Lenses? _____

Hearing Aid? _____

Any specific activities to be restricted? _____ Receiving
Special Education Services? _____

Can your child participate in water activities (sprinklers)? _____

C. Please describe any conditions that our staff should have knowledge of in order to assure a safe environment for your child: _____

D. Parent Authorization (required):

This health history is correct as far as I know, and the person herein described has permission to engage in all prescribed program activities, except as noted above. In the event that my emergency contact person or I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by the program Administrator to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my child as named above. I, the undersigned, hereby acknowledge my child's voluntary participation in the recreational and educational activities of the Eastern Suffolk BOCES Extended Day Enrichment Program.

Legal Guardian Signature: _____ **Date:** _____

(Note: please use one page for each child)

A. Student Name (#2): _____ Date of Birth: _____
Male () Female ()

Home Address: _____

Home Phone: _____ Cell Phone _____

Email Address (please print): _____

B. Health History (list month and year if student had illness):

Ear Infection -	Mumps -	Rheumatic Fever -	Asthma -
Poison Ivy -	Hay Fever -	Measles -	Convulsions -
Insect Stings -	Chicken Pox -	Diabetes -	German Measles -

Any allergies (foods, drugs, plants, insects, other?) _____

Please explain: _____

Operations or serious injuries (type and date): _____

Chronic or recurring illness: _____ Other diseases: _____

Does your child wear glasses? _____ Does he/she wear them all the time? _____ Contact Lenses? _____
Hearing Aid? _____

Any specific activities to be restricted? _____ Receiving
Special Education Services? _____

Can your child participate in water activities (sprinklers)? _____

C. Please describe any conditions that our staff should have knowledge of in order to ensure a safe environment for your child: _____

D. Parent Authorization (required):

This health history is correct as far as I know, and the person herein described has permission to engage in all prescribed program activities, except as noted above. In the event that my emergency contact person or I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by the program Administrator to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my child as named above. I, the undersigned, hereby acknowledge my child's voluntary participation in the recreational and educational activities of the Eastern Suffolk BOCES Extended Day Enrichment Program.

Legal Guardian Signature: _____ **Date:** _____

**PAYMENT RECORD FOR CHILD CARE REGISTRATION FEE
AND FIRST MONTH'S PREPAID TUITION**

Parent/guardian name: _____
(please print)

Home Address: _____
(if Great River, please indicate P.O. Box Number)

Home Phone #: _____ Work Phone #: _____

Name/Address of Employer: _____

Email address: _____
(please print)

Child(ren) Registered:

Name: (#1) _____ Grade: _____ School: _____ AM Prog.: _____ PM Prog: _____

Name: (#2) _____ Grade: _____ School: _____ AM Prog.: _____ PM Prog: _____

Additional Notes for Parents/Guardians Regarding Payment

- a. At registration, you must inform Cheryl Rigogliosi if your child receives **Free/Reduced lunch**.
- b. Any **past due balance** must be paid in full at registration prior to your child being admitted to our programs.
- c. You will be responsible for at least the **8-day minimum rate each month**, even if you do not use 8 days per month. *Daily rates are charged for the amount of days over 8 that your child has attended in each month.* You must choose the frequency of the invoicing (8-day minimum vs. monthly) and this can only be changed once per school year. All changes must be made in writing by emailing Diana Fraccalvieri and Pam Rosand, including if you are dropping out of our programs; Diana.fraccalvieri@eischools.org, Pamela.rosand@eischools.org.
- d. **Late Pick Up Fees/After School Prog. only (After 6:00 pm):** Please be aware that we do charge \$35 for the first late pick up, \$40 for the 2nd and 3rd late pick up – enrollment is cancelled at the 3rd late pick up.
- e. **Please initial:** I have read the above “additional notes” and agree to the terms.

Initial here

FOR OFFICE USE ONLY

(Payment Information)

Student Name:	Parent last name if differs from student:
Student ID #	
8 day minimum for Early Morn. Prog.:	Flat Discount Fee:
8 day minimum for After School Prog.:	Flat Discount Fee:
Registration Fees:	
TOTAL DUE TO START PROGRAM(S):	