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**Mary Robinson Cohen, M.A., J.D.**  
**Superintendent and Principal**

2014-2015

Dear Parent or Guardian:

Welcome to Roosevelt Child Care Before and After School and Pre-school Program.

**Completed registration forms along with a registration fee of \$30.00 (\$20.00 for second child) and your first month's payment must be received upon registration.**

Registration will only be completed when all of the following forms have been filled out and returned to the RPS office:

- Registration and Student Information Form
- Registration Agreement and Emergency Medical Authorization
- DYFS & Expulsion Statements
- Registration/Processing fee of \$30.00

**Your child will not be able to attend unless the above registration forms are complete.**

Please read the attached and complete. We are looking forward to an exciting year and welcome your interest and participation as we work together to make the RPS Child Care Program a successful and enriching experience for your child (ren). If you have any additional questions, please contact (609) 752-7681.

Sincerely,

*Mary Robinson Cohen*  
*Superintendent and Principal*

# Roosevelt Child Care Registration Form 2014-2015

Start Date \_\_\_\_\_

Classroom Teacher \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Student's Name                      Age      Grade      Birthdate      Gender: M/F

Circle Days- **BEFORE AND AFTER CARE**

7:00 – 8:10 AM -      M Tu W Th F  
3:00 – 5:00 PM -      M Tu W Th F  
3:00 – 6:00 PM -      M Tu W Th F

Circle Times & Days of Attendance:      **PRE-SCHOOL CONNECTION**

12:30 – 3:00 p.m.      M Tu W Th F  
12:30 – 5:00 p.m.      M Tu W Th F  
12:30- 6:00 p.m.      M Tu W Th F

Parent or Guardian with whom student resides:

Name \_\_\_\_\_ Street Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Name of Employer \_\_\_\_\_  
Work Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
E-Mail \_\_\_\_\_ E-Mail \_\_\_\_\_

**Emergency Numbers:** List two **LOCAL** adults who can pick up your child if you are delayed or if there is an emergency. Be sure to check with these individuals before listing their names. It is mandatory that we have local emergency names. **All changes must be made in writing to the office.**

1. Name \_\_\_\_\_ Street Address \_\_\_\_\_  
Day Phone \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
2. Name \_\_\_\_\_ Street Address \_\_\_\_\_  
Day Phone \_\_\_\_\_ City, State, Zip \_\_\_\_\_

List any individual restricted by court order from picking up your child (attach copy of court order).

Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_

**Circle one: I Do I Do Not** give permission for my child to appear in any media coverage approved by the administrative staff.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

**ROOSEVELT CHILD CARE  
REGISTRATION AGREEMENT**

1. I understand that I am enrolling my child \_\_\_\_\_ for the entire 2014-2015 school year (September to June).
2. I understand that on days that school is closed or closes early because of emergency conditions there will be no Child Care Program.
3. I understand that I am responsible for monthly payments of contracted fees to be **paid by the 15<sup>th</sup> of each month** preceding service. I will give at least one month's notice in writing of withdrawal from the program. There is a \$25.00 fee for withdrawing if proper prior notification is not given. I understand that there is a one-month minimum for registration. Payment is due upon registration.
4. I agree to pay \_\_\_\_\_ per month for the Child Care Program. Payments are made payable to **Roosevelt Bd. Of Ed.**
5. I agree that \_\_\_\_\_ will be responsible for the monthly tuition.
6. Any payment not received by the 15<sup>th</sup> may be subject to a late fee of \$20. I understand that in the event of non-payment, I am responsible for all costs of collection including attorney fees and court costs.
7. In the event of illness, vacation or other absences (sports, music, etc.) and other school activities, I am responsible for my child's full tuition in the Child Care Program. I understand I am responsible for notifying the Child Care Program office.
8. The staff will assume full responsibility for my child from the time my child arrives until pick up time. **Pick up time is 6:00 PM as contracted** and I agree that my child will be picked up by this time. An authorized adult must sign in each child during arrival or out at dismissal. I am aware that there is a fee for late pick up.
9. I give my permission for my child to participate in walks and field trips. Details and information about field trips will be provided.
10. If a medical emergency arises, the Child Care Program staff will attempt to contact me immediately. If I cannot be reached, the staff will contact the child's doctor. If the emergency is such that immediate hospital attention is necessary, my child may be taken to the nearest hospital.
11. I have read and understand the statement of reporting child abuse and neglect.
12. I have read and agree to the Child Care Program's Expulsion Policy.

I agree to adhere to the RPS Child Care Program policies and give my permission for my child, \_\_\_\_\_ to participate fully in this program.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Communication with the staff can be arranged through the Office at (609) 448-2798 between the hours of 8:00 am – 3:00 pm. OR you can call between the hours of 7:00 – 8:00 a.m. or from 3:00 – 6:00 p.m.

**Roosevelt Child Care Program  
Emergency Medical Authorization**

*I hereby authorize emergency medical care for my child \_\_\_\_\_ during attendance at the Roosevelt Child Care Program, if in the judgement of the staff; treatment is required for an injury or illness. I, hereby, also authorize the administration of anesthetics and recourse to other procedures deemed necessary by the attending physician. I understand that, whenever possible, I will be notified at the earliest possible time should prior notice prove impossible.*

**The physician of my choice is \_\_\_\_\_ Phone \_\_\_\_\_.**

**The hospital emergency room of my choice is (if possible): \_\_\_\_\_.**

**My child is allergic to the following:**

**Medications:** \_\_\_\_\_

**Foods:** \_\_\_\_\_

**Other:** \_\_\_\_\_

*I understand that I am financially responsible for any expenses for medical care or transportation incurred on my child's behalf.*

**Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_.**

**Other Information About My Child**

List your child's interests in areas such as music, sports and hobbies.

Describe any special concerns that you may have regarding you child's full participation. Please add a separate sheet of paper if necessary.

Note any special treatment or care your child is receiving, e.g. medication, allergy shots, psychological counseling, speech therapy.

List any other activities that you expect your child to participate in during the 2014-2015 school year, e.g. scouts, school clubs, sports.