AFTERCARE DISMISSAL & TRANSPORTATION POLICY

DISMISSAL/PICKING-UP STUDENTS -Students will only be released to the child's parent/guardian or the responsible party designated by the child's parent/guardian in writing. This may be accomplished by noting who will be picking up the child on the weekly sign-up form or by notifying the school in writing. The parent or designee must sign the student out when picking up him or her at the end of the day. Valid Identification IS required!

PICK-UP PROCEDURE

Parents will enter the parking lot from Holland Street and park on the street or the school's small front office parking lot also on Holland Street, and they are expected to come to collect their child from the facility through the School's Main entrance on Holland Street prior to 4:00 pm or the Cafeteria Entrance between 4:00 pm and 5:30 pm. An adult attendant from Aftercare will answer the door. The Parent or Guardian will then sign out the child(ren) which notes the end time for that day, which will calculate the amount charged for that day's use of Aftercare Services.

Aftercare Pickup Door #1 - The Parent Pick-up Location **PRIOR TO 4:00 pm** is the Main Office Door. *The Main Office double doors have the school's crest on the glass.*

Aftercare Pickup Door #2-The Parent Pick-up Location **AFTER 4:00 pm** is the Aftercare Door on Holland Street, located to the left of the school's main office double doors.

TRANSPORTATION-This aftercare program does not take students on excursions or field trips that involve vehicular transportation off-site. Movement from one location to the next on the grounds of the center property will be on foot except to practice drills involving walking to a relocation site for safety.

EMERGENCY AND SAFETY – With your child's safety in mind, it is most important that your contact information is kept current. Please inform us of any changes as they may occur so that we always have the most up-to-date information to help your child in the event of an emergency.

EMERGENCY TRANSPORTATION - In the event of an emergency requiring students to be driven away from the school property for their own safety, following the approved La Salle Academy emergency policy, AFTERCARE students would be transported by Emergency Medical Services or La Salle Academy staff members to either the established off-site reunification location, which is John Paul II Special Learning Center, 1092 Welsh Road, Shillington, PA 19607, or the location as directed by local E.M.S. or Law Enforcement.

HEALTH POLICIES – The Reauthorized CCDBG Fund requires lead agencies to issue policy and regulations regarding recommendations for health and safety topics, outlined in p 98.41(a)(1), that are designed, implemented, and enforced to protect the health and safety of children.

Staff working in this facility maintain training in the recognition of potential signs and symptoms of shaken baby syndrome and abusive head trauma, strategies for coping with a crying, fussing, or distraught child and maintain skills to address the prevention and identification of child maltreatment.

Training is maintained by all staff that work with children annually. We share your goal as parents and family members who care for the children whom you bring to this child care facility, La Salle Academy. If you want learn more about health policies that pertain to this child care center the prevention of shaken baby syndrome, abusive head trauma and child maltreatment requirements please contact the Director, Mrs. Donahue, or the Office of Child Development and Early Learning, Northeast Scranton Office Phone: 1-800-222-2108.

QUESTIONS OR CONCERNS:

If you have any further questions or concerns about this Aftercare program, you are encouraged to call Mrs. Elizabeth Donahue, Director, 610-777-7392 or email Donahue@lsabear.com or the Office of Child Development and Early Learning, Northeast Scranton Office Phone: 1-800-222-2108 or www.dhs.pa.gov or www.education.pa.gov.

AFTERCARE FAMILY REGISTRATION FEE - There is a $25.00 non-refundable, per family fee for the AFTERCARE PROGRAM per school year. A bill through the STS program will be sent via email to each registered family. We can accept a check for the family registration fee only. If using a check, kindly make check payable to "La Salle Academy" and list "AFTERCARE REGISTRATION FEE" in the memo line.

PAYMENT- AFTERCARE PROGRAM services are billed at the end of each week following services through the STS payment system and are due upon receipt. Payments are made through the STS Program in order to eliminate the need to handle money and calculate bills during the time children are in AFTERCARE. This frees AFTERCARE PROGRAM staff to give more attention to the children.

Arrival Time:	Departure Time:	Per Child Cost:
2:30 PM	Up to 4:15PM	$ 12.00
4:15 PM	Up to 5:30 PM	$ 15.00

Add $10.00 per child per day for late pick-ups between 2:35pm and 3:00pm.
Add $5.00 per child for Emergency Add-ons to Aftercare roster after 10:00am.
Add $5.00 per child for every 5 minutes after 5:30 pm up to 6:00 pm
Add $50.00 per child for every 15 minutes after 6:00 PM

**3-year-old Prekindergarten 1 students may begin Aftercare at 1:30 pm academic program dismissal.*

CHANGES TO SCHEDULE – Changes to a child's AFTERCARE PROGRAM schedule must be made in writing and sent to the office as soon as possible. All communications should be marked "**Attention AFTER CARE Coordinator**." In the event of an emergency, a phone call may be placed to the office. **If a change occurs after 10:00am on a day the child is scheduled for AFTERCARE, a $5.00 per child fee is charged.**

MINIMUM CHARGE – There is a minimum charge for each child scheduled for the AFTERCARE Program. It is equivalent to the first period rate of $12.00 per child.

DROP-IN CHARGE – Students who are not picked up at regular dismissal time, 2:30 pm, left to wait for a ride or students who do not have a prior reservation for a particular day are considered Drop-in status. The Drop-in Status surcharge is $10.00 per child per day for any time between 2:35 pm and 3:00 pm following a regular day (2:30 pm) dismissal.

LATE PICK-UP CHARGE – The AFTERCARE PROGRAM will end at 5:30PM sharp. All children are to be picked up before that time. We ask parents not to extend this time. An additional charge of $ 5.00 per child will be added to the week's bill for the first 5 minutes after 5:30 pm and $ 50.00 per child for each additional 15 minutes after 6:00 pm.

ELIGIBILITY – La Salle Academy Students in full-day Prekindergarten 1 (3-year-old) or Prekindergarten 2 (4-year-old), Kindergarten, or Grades 1-8.

ACCEPTANCE INTO THE PROGRAM: - based on the following criteria:

- Families currently enrolled in the AFTERCARE PROGRAM and using it on a regular basis.
- Families currently registered on the waiting list.
  - o Priority to date placed on the waiting list.
  - o Full-time use of the program
- New families registering for the AFTERCARE PROGRAM waiting List.
- Special Needs (determined by School Principal and AFTERCARE Coordinators)

PROCEDURE TO ENROLL IN AFTERCARE PROGRAM:

1. Complete and submit La Salle Extended Care Program Weekly Registration Form
2. Complete these required forms: (Please leave no spaces blank when completing these forms or your child's participation in Aftercare may be delayed)
   a. EMERGENCY CONTACT/PARENTAL CONSENT FORM *(Updated every 6 months)*
      55 PA CODE CHAPTERS 3270.124(a)(b), 3280.181&182: 3290.181 &182
   b. COMMONWEALTH OF PENNSYLVANIA DEPT OF HEALTH, PRIVATE PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE (Annual Completion)
   c. CHILD HEALTH REPORT (Annual Completion)
      (55 PA CODE 3270.131, 3280.131 & 3290.131)
   d. AGREEMENT form (Annual completion)
      (55 PA CODE CHAPTERS 3270.123 &181(C); 3280.123 & 181(c); 3290.123 &. 181(c)
3. $25.00 annual per family registration fee, non-refundable will be billed through the STS system the first time a family uses the AFTERCARE PROGRAM. However, families can also pay the FAMILY Registration Fee with a check payable to "La Salle Academy".

WEEKLY REGISTRATION FORM – This form is sent home each week in the Wednesday Take-home Folder. The form is also available as a PDF on the school's web-site and can be printed as necessary, (for example if your child misses school on Wednesday and would be unable to receive the form until Thursday, etc.) The weekly registration form should be completed and returned to the school the next day, (Thursday) of the week prior to service (date is on the form). If the form is not returned on time, it is possible that your child may not be permitted to attend the AFTERCARE PROGRAM for that week. Forms will be collected on Thursday during homeroom. This allows the coordinator to ensure there are enough aides to support the students for each day of the program the following week.

Belief Statement

We, the Administration, Faculty and Staff of La Salle Academy, believe that preventing, recognizing, responding to, and reporting shaken baby syndrome and abusive head trauma (SBS/AHT) is an important function of keeping children safe, protecting their healthy development, providing quality child care, and educating families.

Background

SBS/AHT is the name given to a form of physical child abuse that occurs when an infant or small child is violently shaken and/or there is trauma to the head. Shaking may last only a few seconds but can result in severe injury or even death.

According to Pennsylvania Child Care Code 55, each child care facility licensed to care for children up to five years of age shall develop and adopt a policy to prevent SBS/AHT.

Procedure/Practice

Recognizing:

Children are observed for signs of abusive head trauma including irritability and/or high pitched crying, difficulty staying awake/lethargy or loss of consciousness, difficulty breathing, inability to lift the head, seizures, lack of appetite, vomiting, bruises, poor feeding/sucking, no smiling or vocalization, inability of the eyes to track and/or decreased muscle tone. Bruises may be found on the upper arms, rib cage, or head resulting from gripping or from hitting the head.

Responding to:

If SBS/ABT is suspected, staff will:

- o Call 911 immediately upon suspecting SBS/AHT and inform the director.
- o Call the parents/guardians.
- o If the child has stopped breathing, trained staff will begin pediatric CPR.

Reporting:

- o Instances of suspected child maltreatment in child care are reported to Office of Child Development and Early Education (OCDEL) by calling 1-800-222-2108 or by emailing www.dhs.pa.gov.
- o Instances of suspected child maltreatment in the home are reported to Childline of Berks County Phone number: 1-800-932-0313.

Prevention strategies to assist staff* in coping with a crying, fussing, or distraught child

Staff first determine if the child has any physical needs such as being hungry, tired, sick, or in need of a diaper change.

If no physical need is identified, staff will attempt one or more of the following strategies:

-Rock the child, hold the child close, or walk with the child.
-Stand up, hold the child close, and repeatedly bend knees.
-Sing or talk to the child in a soothing voice.
-Gently rub or stroke the child's back, chest, or tummy.
-Offer a pacifier or try to distract the child with a rattle or toy.

-Take the child for a ride in a stroller.
-Turn on music or white noise.

In addition, the facility:

- Allows for staff who feel they may lose control to have a short, but relatively immediate break away from the children.
- Provides support when parents/guardians are trying to calm a crying child and encourage parents to take a calming break if needed.

Prohibited behaviors

Behaviors that are prohibited include (but are not limited to):

- shaking or jerking a child
- tossing a child into the air or into a crib, chair, or car seat
- pushing a child into walls, doors, or furniture

Strategies to assist staff members understand how to care for infants and young children

The Reauthorized CCDBG Fund requires lead agencies to issue policy and regulations regarding recommendations for health and safety topics, outlined in p 98.41(a)(1), that are designed, implemented, and enforced to protect the health and safety of children.

All staff take training on SBS/AHT within first two weeks of employment. Training includes recognizing, responding to, and reporting child abuse, neglect, or maltreatment as well as the brain development of children up to four years of age or in the aftercare program. Staff review and discuss:

Staff working in this facility maintain training in the recognition of potential signs and symptoms of shaken baby syndrome and abusive head trauma, strategies for coping with a crying, fussing, or distraught child and maintain skills to address the prevention and identification of child maltreatment.

Resources

- Childline of Berks County phone number - 1-800-932-0313
- Police - 911
- PA Office of Childhood Development and Early Learning, Northeast Region, Phone 1-800-222-2108, email kgruber@pa.gov

Parent web resources

- The American Academy of Pediatrics: www.healthychildren.org/English/safety-prevention/at-home/Pages/Abusive-Head-Trauma-Shaken-Baby-Syndrome.aspx
- The National Center on Shaken Baby Syndrome: http://dontshake.org/family-resources
- The Period of Purple Crying: http://purplecrying.info/

La Salle Academy Prevention of Shaken Baby Syndrome and Abusive Head Trauma Policy

I made the Application

This policy applies to children up to four years of age or in the aftercare program and their families, operators, early educators, substitute providers, and uncompensated providers.

Communication

Staff*

- Within 30 days of adopting this policy, the child care facility shall review the policy with all staff who provide care for children up to four years of age or a child in the aftercare program.
- All current staff members and newly hired staff will be trained in SBS/AHT before providing care for children up to four years of age or a child in the aftercare program.
- Staff will sign an acknowledgement form that includes the individual's name, the date the center's policy was given and explained to the individual, the individual's signature, and the date the individual signed the acknowledgment
- The child care facility shall keep the SBS/AHT staff acknowledgement form in the staff member's file.

Parents/Guardians

- Within 30 days of adopting this policy, the child care facility shall review the policy with parents/guardians of currently enrolled children up to four years of age or in the aftercare program.
- A copy of the policy will be given and explained to the parents/guardians of newly enrolled children up to four years of age or in the aftercare program on or before the first day the child receives care at the facility.
- Parents/guardians will sign an acknowledgement form that includes the child's name, date the child first attended the facility, date the operator's policy was given and explained to the parent, parent's name, parent's signature, and the date the parent signed the acknowledgement
- The child care facility shall keep the SBS/AHT parent acknowledgement form in the child's file.

** For purposes of this policy, "staff" includes the operator and other administration staff who may be counted in ratio, additional caregivers, substitute providers, and uncompensated providers.*

8/27/2023
Effective Date

This policy was reviewed and approved by: Elizabeth M. Donahue 8/27/2023
Director Date

8/2023 _____ _____ _____
Annual Review Dates

La Salle Academy Emergency Contact Form

Student Name_____ Grade_____ Date of Birth_____

Address_____ City_____ State_____ Zip _____

Public School District_____ Bus # _____

Student lives with: ☐ **Parents** ☐ **Mother** ☐ **Father** ☐ **Other**_____

1. **Parent's Name/Legal Guardian**_____

   Phone (___) _____ (cell or home) Email_____

   Address_____ City_____ State_____ Zip _____

   Employer_____ Work Tel. # (___)_____ ext.)_____

   Address_____ City_____ State_____ Zip _____

2. **Parent's Name/Legal Guardian**_____

   Phone (___) _____ (cell or home) Email_____ _____

   Address_____ City_____ State_____ Zip _____

   Employer_____ Work Tel. # (___) _____ (ext.)_____

   Address_____ City_____ State_____ Zip _____

Parents/Guardians listed above have permission to pick up the child unless otherwise indicated. Notify the school principal immediately if there are any court orders restricting non-custodial parents or others from contact with the child. Provide the principal with a copy of the order.

EMERGENCY CONTACT PERSONS

1. Full Name_____ Relationship to Child_____ Phone # when child in in care_____

   Address_____ City_____ State_____ Zip _____

2. Full Name_____ Relationship to Child_____ Phone # when child in in care_____

   Address_____ City_____ State_____ Zip _____

PERSON(S) TO WHOM CHILD MAY BE RELEASED

1. Full Name_____ Relationship to Child_____ Phone # when child in in care_____

   Address_____ City_____ State_____ Zip _____

2. Full Name_____ Relationship to Child_____ Phone # when child in in care_____

   Address_____ City_____ State_____ Zip _____

PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENT CONSENT

Emergency Medical Care _____	**Admin of minor first-aid** _____
Walks & trips _____	**Transportation by faculty** _____

X _____ **X** _____

Parent/Guardian Signature Date

OVER→

MEDICAL/PHYSICAL INFORMATION

Child's Medical Care Provider_____ Phone #_____

Address_____ City_____ State_____ Zip_____

Hospital Preference_____ Second Choice_____

Health insurance/Medical Assistance provider _____ Policy # (required) _____

Does the student have any medical problems/disabilities/allergies? No____ Yes____ If yes, please describe _____

_____

Does the student require medication for this medical problem/disability/allergy? No____ Yes____ If yes, please list current medications and dosages

_____

_____

In case of a medical emergency, is there any medical or dietary information or medications we would need to be aware of? No____ Yes____

If yes, please list_____

_____

Does any medication need to be administered at school? No___ Yes___

If yes, please acquire the Request to Administer Medication form and a doctor's order.

Does the student **carry or keep** the following in the nurse's office?

Inhaler? No___ Yes___ type _____

Grades 5-8 only: Is the child able to self-administer the inhaler medication? No___ Yes___

Epi-Pen? No___ Yes___ type_____

Grades 5-8 only: Is the child able to self-administer the inhaler medication? No___ Yes___

Does the student have any allergies to medication? No___ Yes___ type_____

The School has my permission to administer the following medication(s) to my child if deemed necessary. Please circle one:

Acetaminophen (Tylenol)	No /Yes	Ibuprofen (Advil, Motrin)	No /Yes
Antacids	No /Yes	Nasal Decongestant (Non-Sudafed)	No /Yes
Imodium (Diarrhea)	No /Yes	Allergy Eye Drops	No /Yes
Benadryl (Allergic Reaction)	No /Yes	Allergy Medication (Claritin, Zyrtec)	No /Yes

No___ Yes___ I give permission for the school nurse to share information concerning my child's health with appropriate personnel in order to ensure the students optimal care and safety.

X _____ **X** _____

Parent/Guardian Signature Date

PERIODIC REVIEW

In accordance with DHS regulations, a six-month review of information is required after initial form is completed. You will be notified with the date of review and asked for a signature at that time.

_____ _____

Periodic Review #1/ Parent/Guardian Signature Date

_____ _____

Periodic Review #2/Parent/Guardian Signature Date

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.

H511.336 (Rev. 5/02)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE

DATE _____ 20 ____

NAME OF SCHOOL _____ GRADE HOMEROOM _____

NAME OF CHILD			DATE OF BIRTH	SEX
Last	First	Middle		☐ M ☐ F

ADDRESS

No. and Street	City or Post Office	Borough or Township	County	State	Zip Code

MEDICAL HISTORY

IMMUNIZATIONS AND TESTS

VACCINE	Enter Month, Day, And Year Each Immunization Was Given DOSES			BOOSTERS & DATES	
Diphtheria and Tetanus (Circle): DTaP, DTP, DT, TD	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (Circle): OPV, IPV	1 / /	2 /	3 /	4 /	5 /
Measles, Mumps, Rubella	1 / /	2 /			
Hepatitis B	1 / /	2 / /	3 / /		
HIB	1 / /	2 / /	3 / /		
Varicella	1 / /	2 / /	Varicella Disease or Lab Evidence Date: _____		
Other _____					

☐ MEDICAL EXEMPTION The physical condition of the above named child is such that immunization would endanger life or health
☐ RELIGIOUS EXEMPTION (Includes a strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent/guardian)

If Applicable:

Tuberculin Tests Date Applied	Arm	Device	Antigen	Manufacturer	Signature
Date Read	**Results (mm)**		**Signature**		

Follow-Up of significant tuberculin tests:
Parent/Guardian notified of significant findings on _____.
Date

Result of Diagnostic Studies: _____.
Date

Preventive Anti-Tuberculosis - Chemotherapy ordered. ☐No ☐ Yes _____
Date

(Continued on Back)

Significant Medical Conditions

	Yes	No	If Yes, Explain
Allergies	☐	☐	
Asthma	☐	☐	
Cardiac	☐	☐	
Chemical Dependency	☐	☐	
Drugs	☐	☐	
Alcohol	☐	☐	
Diabetes Mellitus	☐	☐	
Gastrointestinal Disorder	☐	☐	
Hearing Disorder	☐	☐	
Hypertension	☐	☐	
Neuromuscular Disorder	☐	☐	
Orthopedic Condition	☐	☐	
Respiratory Illness	☐	☐	
Seizure Disorder	☐	☐	
Skin Disorder	☐	☐	
Vision Disorder	☐	☐	
Other (Specify)	☐	☐	

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her education? If so, specify _____

Report of Physical Examination

• Height (inches)				
• Weight (pounds) BMI				
• Pulse ( )				
• Blood Pressure /				
• Hair/Scalp				
• Skin				
• Eyes/Vision				
• Ears/Hearing				
• Nose and Throat				
• Teeth and Gingiva				
• Lymph Glands				
• Heart — Murmur, etc.				
• Lung — Adventitious Findings				
• Abdomen				
• Genitourinary				
• Neuromuscular System				
• Extremities				
• Spine (Presence of Scoliosis)				

_____
Date of Examination

_____
Signature of Examiner

_____
Print Name of Examiner

_____
Address

_____
Telephone Numbe

AFTERCARE AGREEMENT 2023-24

55 PA CODE CHAPTERS 3270.123 &.181(C); 3280.123 &.181(c); 3290.123 &.181(c)

NAME OF CHILD		
FEE AMOUNT $ 12.00 -15.00/Day	PER-DAY-WEEK See Extended Care Rules	DAY PAYMENT TO BE MADE Due upon receipt through STS System

Services to be provided as part of the day care fee (examples; transportation, care, meals, etc.)

See La Salle Extended Care Program 2023-24 Rules and Rate information Packet or Schedule, Fees, Late Fees, Ground Rules, Weekly Registration, Ground Rules, Weekly Registration, Billing, Transportation, Questions or Concerns

CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
2:30 PM	Varies up to 5:30 PM	See Emergency Contact//Parental Consent Form
LATE FEE $ $5.00-50.00	PER MIN-HR See Rate Info	

Extra services to be provided at an additional fee if applicable

I, the parent/guardian;

- [X] received complete written program information at the time of enrollment. (§ 3270.121, 3280.121, 3290.121)
- [X] agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minumum. (§ 3270.124, 3280.124, 3290.124)

SIGNATURE-OPERATOR DATE SIGNATURE-PARENT OR GUARDIAN DATE

DATE OF CHILD'S ADMISSION	PERIODIC REVIEW
DATE OF WITHDRAWAL	SIGNATURE-PARENT OR GUARDIAN DATE

MEDICATION LOG

55 Pa. Code §3270.133; §3280.133; §3290.133

PLEASE PRINT

Page _____ of _____

Child's Name: _____ Medication: _____

☐ Prescription ☐ Non-Prescription Refrigeration Required: ☐ YES ☐ NO

If Prescription, Prescriber's Name: _____ Telephone: _____

Dosage Amount: _____ Time to Administer: _____ a.m. _____ p.m. _____ times/day

Dates for Administration: From _____ (Date) To _____ (Date)

Special instructions i.e., symptoms signaling need for administration, medication indications, reasons to hold medication, contraindications:

_____

_____

I give permission to administer medication to my child as stated above.

_____ (Parent Signature) _____ (Date)

FACILITY STAFF COMPLETE THIS SECTION				
Date Administered (mm/dd/yyyy)	**Time Administered (a.m. / p.m.)**	**Amount of Medication Administered**	**Comments/Reactions**	**Staff Initials**

This information is confidential and may not be shared or released without the parent's written permission.

Aftercare Reservation Form

Due Thursday by 5pm, the week prior to service

Family Name _____ Week Attending _____

Enter Date:	Pickup time:	Pick up info, please print clearly:	Students attending, name & grade:	
Monday		Full name: Relationship & Cell #:	1. 2. 3.	
Tuesday		Full name: Relationship & Cell #:	1. 2. 3.	
Wednesday		Full name: Relationship & Cell #:	1. 2. 3.	
Thursday		Full name: Relationship & Cell #:	1. 2. 3.	
Friday		Full name: Relationship & Cell #:	1. 2. 3.	

Pricing per child:

2:30 PM* to 4:15 PM $12.00
4:15 PM to 5:30 PM $15.00

** 3 year old Pre-Kindergarten 1 students may begin Aftercare at 1:30 pm academic program dismissal*

Annual registration fee $25.00 per family
Add $10.00 per child per day for late pick-ups between 2:25pm and 3:00pm
Add $5.00 per child for emergency add-ons to Aftercare roster after 10:00am Thursday, prior to service
Add $5.00 per child for every 5 minutes after 5:30pm up to 6:00pm
Add $50.00 per child for every 15 minutes after 6:00pm

_____

Parent/Guardian name, printed & signed - required