

SACHEM CENTRAL SCHOOL DISTRICT
SACC REGISTRATION FORM 2018-19

Child's Name: _____ School: _____

Date of Birth: _____ Grade as of Sept. 2018: _____ Gender: _____

<u>AM:</u>	Start Date: _____
<i>(Please circle:)</i> M T W TH F	

<u>PM:</u>	Start Date: _____
<i>(Please circle:)</i> M T W TH F	

Student I.D. # _____

Home Phone: _____

PARENT/GUARDIAN INFORMATION:

(1) Name: _____ Relationship to Child: _____

Home Address: _____ Town: _____

Place of Employment: _____ Work #: _____ Cell #: _____

(2) Name: _____ Relationship to Child: _____

Home Address: _____ Town: _____

Place of Employment: _____ Work #: _____ Cell #: _____

NAMES OF LOCAL PERSONS (18 and over) AUTHORIZED TO PICK UP MY CHILD:

Name: _____ Relationship to Child: _____

Home Phone # () _____ Cell # () _____

Name: _____ Relationship to Child: _____

Home Phone # () _____ Cell # () _____

Name: _____ Relationship to Child: _____

Home Phone # () _____ Cell # () _____

****Please complete this form in its entirety.****

REVERSE SIDE MUST BE COMPLETED

Child's Name _____ Student I.D. # _____

- **Online monthly prepayments will be paid on the first day of each month. If I need to pay by money order I may do so at the Child Care site. Cash will not be accepted. Failure to pay in a timely manner is reason for dismissal from the program. All receipts must be retained by the parent. The Child Care Office will not provide any further record of payment.**
- My child must be signed in and out of the program by myself or another adult daily.
- It is my responsibility to notify the Child Care Office of any custodial arrangements. My child may be released to either parent unless we have court documentation.
- A new registration form must be submitted each year. Prior registration forms **will not** be accepted.

IMPORTANT - MEDICAL INFORMATION

- The above named child has: (please circle) allergies, asthma, seizure disorder, diabetes or other medical needs: _____

- The above named child may require the following medication during program hours:
(Please circle) Epi-Pen, Epi-Pen Jr., Benadryl, Diastat, Inhaler or other medication:

*****Please see medication guidelines in the Parent Handbook*****

The above named child has the following dietary, medical or activity restrictions:

Doctor's Name: _____ Telephone: _____

I have read the information on this registration form and the Parent Handbook and agree to the conditions therein.

Signature of Parent/Guardian _____ Date: _____

During the period of May 21, 2018 – August 15, 2018, all registration forms must be mailed to:

Sachem Central School District
Administrative Offices
Child Care Office, Room 103
51 School Street
Lake Ronkonkoma, NY 11779
Attn: Geri Parrotta