



SFCS Summer Care Registration Form 2017

For students ages 3 – 6, if 6 by Sept 1, 2017 please use other form

CHILD'S NAME: _____ Current School: _____ Current Grade: _____
 Age: _____ Date of Birth: _____

DIRECTIONS: To register, complete this form, include/attach a \$60.00 non-refundable registration/activity fee per child and return to your after school coordinator by **March 10, 2017 (registration deadline)**. A separate agreement form (filled out completely) is required for each student in a family. Summer Care location is at Holy Spirit School.

Schedule Options:

- Full Day** – Schedule/lunch (7:00 a.m. to 6:00 p.m.) / 5 days week **\$155.00/wk** (per child)
- Half Day** – Morning schedule/lunch (7:00-12:30) / 5 days week **120.00/wk** (per child)
- Half Day** – Afternoon schedule/no lunch (12:30-6:00) / 5 days week **105.00/wk** (per child)
- Partial Week** – 7:00 am-6:00 pm / 2.5 to 3 days week **115.00/wk** (per child)
- Partial Week** – 7:00 am-6:00 pm / 1 to 2 days week **90.00/wk** (per child)

ENROLLING: Check attendance weeks and circle the applicable rate for each week checked.

X	Week No. and Dates	Full Day	Half Day AM/PM	2.5-3 days	1-2 days	Total/Week	Pmt Due date
	1 (May 22 –May 26)	\$155	\$120 / \$105	\$115	\$90	\$	May 20 th
	2 (May 30 –June 2)*	\$124	\$96 / \$84	\$115	\$90	\$	May 20 th

X	Week No. and Dates	Full Day	Half Day AM/PM	2.5-3 days	1-2 days	Total/Week	Pmt Due date
	3 (June 5 –June 9)	\$155	\$120 / \$105	\$115	\$90	\$	June 1 st
	4 (June 12 –June 16)	\$155	\$120 / \$105	\$115	\$90	\$	June 1 st

	5 (June 19 –June 23)	\$155	\$120 / \$105	\$115	\$90	\$	June 15 th
	6 (June 26 –June 30)	\$155	\$120 / \$105	\$115	\$90	\$	June 15 th

X	Week No. and Dates	Full Day	Half Day AM/PM	2.5-3 days	1-2 days	Total/Week	Pmt Due date
	7 (July 3 –July 7)*	\$124	\$96 / \$84	\$115	\$90	\$	July 1 st
	8 (July 10 –July 14)	\$155	\$120 / \$105	\$115	\$90	\$	July 1 st

	9 (July 17 –July 21)	\$155	\$120 / \$105	\$115	\$90	\$	July 15 th
	10 (July 24 –July 28)	\$155	\$120 / \$105	\$115	\$90	\$	July 15 th

X	Week No. and Dates	Full Day	Half Day AM/PM	2.5-3 days	1-2 days	Total/Week	Pmt Due date
	11 (July 31 –Aug 4)	\$155	\$120 / \$105	\$115	\$90	\$	July 25 th
	12 (Aug 7 –Aug 11)	\$155	\$120 / \$105	\$115	\$90	\$	July 25 th

√ - Please note there is NO SUMMER CARE scheduled for the week of August 14th – 18th

*Summer Care is closed Monday, May 29th for Memorial Day and Tuesday July 4th for Independence Day.

BILLING NOTES:

- All 2016-2017 school year tuition must be paid in full prior to attendance.
- Summer Care fees are payable by ACH, credit card, or check/cash. Fees must be paid prior to each week's attendance. Contact TADS (1-800-477-8237) to make changes to your existing payment arrangements or the SFCS Business Office (605-575-3367) to set up your ACH or credit card payment schedule.
- Weekly rate includes lunch (at 11:30 a.m.), and morning/afternoon snacks. (No fast food lunches or delivered meals.)
- There is a \$1 per minute/per child late fee for children who are picked up after the 6:00 p.m. closing time.
- City pool swimming passes are required for any child wishing to participate in Summer Care swimming activities.
- Special activities may require fees (calendars will reflect activities/cost/permission, etc.).

REFUND POLICY:

- Refunds available for full weeks only if notification is made in writing 15 days prior to the payment due date. Refund requests must be made in writing to mhaiar@sfcss.org or mailed to Accounts Receivable at 3100 W. 41st St., Sioux Falls, SD 57105.

No Refunds will be issued for any requests that do not follow these guidelines.

Parent/Guardian Signature (required): _____ Date _____
 Parent/Guardian (Please Print Name): _____

(Date Received _____ Check# _____)



SFCS Summer Care Program Student Emergency Information

****This form must be completed and turned in with registration form by March 10th, 2017****

Please print all information. This form will be used to contact you in case of an emergency. Please be sure all information is correct and complete. This information will be kept confidential.

FAMILY NAME: _____

Child #1: _____	Date of Birth: _____	Age: _____	Current Grade: _____
Child #2: _____	Date of Birth: _____	Age: _____	Current Grade: _____
Child #3: _____	Date of Birth: _____	Age: _____	Current Grade: _____
Child #4: _____	Date of Birth: _____	Age: _____	Current Grade: _____

Father's Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Place of Employment: _____ Cell Phone: _____

E-mail Address: _____

Mother's Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Place of Employment: _____ Cell Phone: _____

E-mail Address: _____

Only the following persons are authorized to pick up my child:

Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____

If parent/guardian cannot be reached in case of emergency, I authorize the Summer Care staff and the following people to grant permission for treatment:

- 1) Name: _____ Home Phone: _____
Relationship to Child: _____ Work Phone: _____
- 2) Name: _____ Home Phone: _____
Relationship to Child: _____ Work Phone: _____
- 3) Physician's Name: _____ Phone: _____
Hospital Preference: _____ Phone: _____

Medical Considerations/Conditions:

Child Name	Allergies/Medical Condition/Medication
_____	_____
_____	_____

- My child's immunization records are on file at SFCS. List Name of School _____
- I have attached my child's immunizations records.

Parent Signature: _____ **Date:** _____

EMERGENCY MEDICAL INFORMATION

In case of school-related accidents, illness or school dismissal communication, please complete.

Hospital Preference: Avera McKennan / Sanford

Please list any significant health information which should be known by the school or attending physician (allergies, asthma, medications, pre-existing condition, etc.):

Parental Consent for my child to take appropriate dosage of non-aspirin pain reliever (if warranted): YES NO

Parental Consent for emergency medical permission:

I hereby consent to any medical services that may be required while any of the above children are under the supervision of an employee of the Sioux Falls Catholic Schools while on school sponsored activities and hereby appoint said employee to act on my behalf in securing necessary medical services from any duly licensed physician or medical emergency provider.

Responsibility for payment of ambulance, physician and/or hospital expenses is that of the parent or guardian.

Parent/Step Parent/Guardian Signature

Date

** You must notify the school as soon as possible if any of the above information changes. **