



**HADDON TOWNSHIP BOARD OF EDUCATION
SCHOOL AGE CHILD CARE**

500 RHOADS AVE, WESTMONT, NJ 08108

BEFORE SCHOOL CARE *AFTER SCHOOL CARE * KINDERGARTEN CARE * SUMMER RECREATION

Dawn Piscopio
Director
856-869-7750 Ext. 1113
sacc@htsd.us
www.haddontwpschools.com

For Office Use Only
Lunch Discount _____
Other _____

**2020-21 School Age Child Care (1-5)
After School Care Registration Form**

Deadline to be entered into the lottery is August 24, 2020. Forms can be emailed to sacc@htsd.us or dropped off at the BOE office in the drop box in the front of the building. Notification of acceptance will be emailed by August 31, 2020.

Child Information

Child Last Name	Child First Name	DOB	School	Grade

After School Care

Checks made payable to: HTBOE
Free and Reduced Lunch 50%

Check Option	Days Per Week	Monthly Fee
	1 day	\$40
	2 days	\$80

Payment is due on the last day of the month

SCHEDULE

Time	Monday	Tuesday	Wednesday	Thursday	Friday
12:30-3:00 PM			Not Open		

(Mark an "x")

FAMILY INFORMATION

	Parent/Guardian #1	Parent/Guardian #2
Name		
Home Address		
City, State, Zip		
Home Phone		
Cell Phone		
Work Phone		
Employer		
Employer City, State		
Email address		
Custody Restrictions?	NO YES: attach a copy of recent order	Comments:

Emergency/Alternate Contact & Authorized Pick Up: If parent/guardian cannot be reached in the event of an emergency, the following person(s) will be contacted. Contacts are expected to act on behalf of the parent/guardian; parental permission to pick up child is implied. Contacts should be available during the hours your child/children attend the SACC program.

List alternate contacts (**OTHER THAN PARENTS**)

Call	Full Name	Relationship to Child	Best Contact Number
First			
Second			

Care Information: Please state information you feel would be useful in meeting your child's needs:

- Allergies
- Medical Conditions/Medications
- Disabilities
- Social/emotional
- Speech/language
- Academic
- Family situations

Medical Permission: If a medical emergency arises, the SACC staff will contact:

- 1) SACC Director 2) Parent/Guardian 3) Emergency Contacts.

If medical assistance is deemed necessary, professional emergency personnel may treat my child. I give permission for said emergency personnel access to my child's health plan. HTSD provides secondary coverage if an accident or injury occurs while participating in HTSD SACC programs.

Child's Physician Name/Phone _____

Child's Primary Insurance Co. & Policy # _____

Parent/Guardian Signature

Date