



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
 Drop In Only _____
 Lunch Discount _____
 Other _____

**2021-22 School Age Child Care
 Before School Care & After School Care
 Registration Form**

Child Information

Child Last Name	First Name	Date of Birth	School	Grade Fall	Gender M F

Before School Care

(Breakfast Included)

Check	FIXED Days per week	Monthly FEE
	1 day	\$45
	2 days	\$65
	3 days	\$90
	4 days	\$115
	5 days	\$125

Check	*FLEX Days per week	Monthly FEE
	1 day	\$ 60
	2 days	\$ 80
	3 days	\$ 105
	4 days	\$130

Drop In Only _____ Drop in Service \$12 per day

Each additional child will not exceed \$60 per month per family

SCHEDULE (FLEX fill in first week schedule)

Check the box the days that your child will attend Before Care

	Monday	Tuesday	Wednesday	Thursday	Friday
Am Care 7 AM					

After School Care

(Snack Included)

Check	FIXED Days per week	Monthly FEE
	2 days	\$110
	3 days	\$140
	4 days	\$170
	5 days	\$200

Check	*FLEX Days per week	Monthly FEE
	2 days	\$125
	3 days	\$155
	4 days	\$195

Drop In Only _____

Drop In 12:30 Dismissal: \$25

Drop In 3pm Dismissal: Fee \$20

SCHEDULE

	Monday	Tuesday	Wednesday	Thursday	Friday
Dismissal-6PM					

(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 most recent order	Comments:

Checks made payable to: HTBOE

Payment is due the 15th of every month (10 equal payments per school year)

Invoices are not necessary to make a payment

DISCOUNTS: Free/Reduced Lunch (Will be verified with BOE)

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 contacts **other than parent/guardian 1 & 2

Call	Full Name	Relationship to Child DO NOT LIST PARENTS	Best Contact Number
First			
Second			
Third			

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.

Parent/Guardian Signature

Date

Child's Physician Name/Phone

Child's Primary Insurance Co. & Policy #
