CKCS BEFORE AND AFTER SCHOOL CARE ADMISSION APPLICATION 2024-2025

Please return the following forms along with your $50.00 per family registration fee to the school office.
If you are needing care for more than one child, you must fill out these forms for each child individually.

Date: _____

TO BE COMPLETED BY PARENT OR GUARDIAN:

STUDENT INFORMATION

Student Name: _____
FIRST NAME MIDDLE NAME LAST NAME

Date of Birth: _____ Gender □ M □ F 2024-25 Grade: _____

Eye Color: _____ Height: _____ Weight: _____

Primary Address: _____
STREET CITY STATE ZIP

PARENT/GUARDIAN INFORMATION

Relationship to child(ren): _____

Parent/Guardian Name: _____
FIRST NAME MIDDLE NAME LAST NAME

Parent/Guardian Address: _____
STREET CITY STATE ZIP

Cell Phone: _____
Home Phone: _____
Work Phone: _____
Primary Email: _____
Occupation: _____
Employer: _____

PARENT/GUARDIAN INFORMATION

Relationship to child(ren): _____

Parent/Guardian Name: _____
FIRST NAME MIDDLE NAME LAST NAME

Parent/Guardian Address: _____
STREET CITY STATE ZIP

Cell Phone: _____
Home Phone: _____
Work Phone: _____
Primary Email: _____
Occupation: _____
Employer: _____

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT #1

Relationship to child(ren): _____

Emergency Contact Name: _____
FIRST NAME MIDDLE NAME LAST NAME

Emergency Contact Address: _____
STREET CITY STATE ZIP

Emergency Contact Phone Number: _____ □ Emergency □ Pick Up

EMERGENCY CONTACT #2

Relationship to child(ren): _____

Emergency Contact Name: _____
FIRST NAME MIDDLE NAME LAST NAME

Emergency Contact Address: _____
STREET CITY STATE ZIP

Emergency Contact Phone Number: _____ □ Emergency □ Pick Up

EMERGENCY CONTACT #3

Relationship to child(ren): _____

Emergency Contact Name: _____
FIRST NAME MIDDLE NAME LAST NAME

Emergency Contact Address: _____
STREET CITY STATE ZIP

Emergency Contact Phone Number: _____ □ Emergency □ Pick Up

EMERGENCY CONTACT #4

Relationship to child(ren): _____

Emergency Contact Name: _____
FIRST NAME MIDDLE NAME LAST NAME

Emergency Contact Address: _____
STREET CITY STATE ZIP

Emergency Contact Phone Number: _____ □ Emergency □ Pick Up

I, _____ give permission for any person above to be contacted and for my child(ren) to be released to those listed as pick up.

Parent/Guardian Signature: _____ Date: _____

STUDENT HEALTH HISTORY

Does your child have:

- *life-threatening health conditions*? □ NO □ YES

If *yes*, please state condition/s:

- Severe allergic reaction to bee sting: □ NO □ YES

If *yes*, please describe reaction:

Anaphylactic: □ NO □ YES

- Severe allergic reaction to food or nuts: □ NO □ YES

If *yes*, please describe food/nut type and reaction:

Anaphylactic: □ NO □ YES

- Mild allergic reaction to food, nuts or other: □ NO □ YES

If *yes*, please describe food/nut/other type and reaction:

- Asthma: □ NO □ YES

If *yes*, will your child require asthma management during afterschool hours: □ NO □ YES

- Diabetes: □ NO □ YES

If *yes*, please describe type:

Self-manageable: □ NO □ YES

Pump: □ NO □ YES

- Heart Condition: □ NO □ YES

If *yes*, please provide diagnosis:

Pacemaker: □ NO □ YES

- Bleeding Disorder: □ NO □ YES

If *yes*, please provide diagnosis:

- Seizure/Neurological Disorder: □ NO □ YES

If *yes*, please describe condition:

- GI/Feeding Condition: □ NO □ YES

If *yes*, please describe condition:

- Bowel/Bladder Condition: □ NO □ YES

If *yes*, please describe condition:

- Behavioral/Emotional Concerns: □ NO □ YES

If *yes*, please describe:

- Visual Impairment: □ NO □ YES

Glasses: □ NO □ YES

Contacts: □ NO □ YES

- Hearing impairment: □ NO □ YES

Hearing Aids: □ NO □ YES

- Other health concerns: □ NO □ YES

If *yes*, please describe:

If your child has any allergies, please have your child's physician complete the *Allergy and Anaphylaxis Emergency Plan.* This plan must be signed by both the physician and parent or legal guardian.

DAILY MEDICATIONS

*A written authorization from a Health Care Provider and parent is required before **any** medication, prescription or over the counter, can be given. Please complete the medication administration form for any medications to be given during after school care.*

Medication need during after school care hours: □ NO □ YES

If *yes*, please specify (authorization needed):

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____

MEDICAL EMERGENCY PLAN

If a child is injured while in our care and needs further first aid or a visit to the doctor, parents/guardians will be called immediately. If we cannot reach you, we will contact the next person listed on your emergency form. Please keep this information updated, notifying us of any changes in your child's emergency form.

In the event of a medical emergency where neither you nor the emergency contacts listed can be reached, CKCS After Care will call an ambulance to transport your child for medical treatment to the nearest hospital or medical facility.

I, _____ have read and understand the Christ the King After
PARENT/LEGAL GUARDIAN PRINTED NAME
School Care Medical Emergency plan. In signing below, I am agreeing with and am providing consent of this plan.

Parent or Legal Guardian Signature: _____ Date: _____

CKCS BEFORE AND AFTER SCHOOL CARE ENROLLMENT CONTRACT 2024-2025

Christ The King Before and After School Care will only be available on in-person instructional days. This eliminates care for any holidays, snow days, school breaks or emergency closures. The Before School Program will be running from 6:50am-7:50am for $7.00 per student a day and the After School Care will be running from 3:00pm-6:00pm, Monday-Thursday for $20.00 per student a day and on Fridays from 1:45pm-5:00pm for $20.00 per student a day. On early release days CKCS After School Care will be backing pick up time to 4 hours after release time. For example, if the school release time is 11:30am, children must be picked up no later than 3:30pm. If ever a child is picked up later than closing time, there will be a $10.00 per minute late fee applied. All payments are to be made directly to Christ the King Catholic School. Payments are due the 15th of each month. **Payments received after the 15th of each month will be subject to a $20 late fee**. ACH is strongly encouraged (see attached form). If you are unable to do ACH, arrangements can be made through the finance office. Accounts will be assessed a $25 return check fee on checks returned for non-sufficient funds.

PROGRAM COSTS	
Non-Refundable Registration Fee	$50.00 per family
Cost Per Attended Day	$20.00 per student
Cost of Morning Care Per Attended Day 6:50-7:50	$7.00 per student
Late Pick Up Fee	$10.00 per minute
Late Payment Fee	$20.00
Non-Sufficient Funds Check Return Fee	$25.00

I have read the CKCS After School Care Enrollment Contract and I understand that I have a moral and legal obligation to fulfill my responsibilities. I further understand that failure to comply with the payment schedule may result in: (A) My child(ren) will be withdrawn from CKCS After School Care; (B) Initiation of legal proceedings; (C) Loss of eligibility for re-registration; (D) subject to Collection Agency.

Parent or Legal Guardian Printed Name: _____

Parent or Legal Guardian Signature: _____ Date: _____

CHRIST THE KING CATHOLIC SCHOOL encourages ACH withdrawals as the primary means of payment for ***regular monthly Before and After School Carae payments***.

**** A new form is required each year to authorize the new Tuition amounts ****

DIRECT PAYMENT Authorization Form 2024-2025

Student Family Last Name _____

I hereby authorize **Christ the King Catholic School** to initiate withdrawals from my account at the financial institution named in this application for payment of my **regular monthly** bills to Christ the King Catholic School. This authorization will remain valid until **June 30, 2025**, or until either I, Christ the King Catholic School, or my financial institution revoke it.

Monthly Before/Afte School Care $_____

I understand that the Direct Payment program is an alternative method of payment only and does not otherwise affect my rights or the rights of Christ the King Catholic School or my financial institution with respect to each other. I further understand that Christ the King Catholic School and my financial institution reserve the right to terminate the Direct Payment plan and/or my participation in it.

This authority is to remain in full force and effect until Christ the King School has received written notification from me (or either of us) of its termination in such time and manner as to afford Christ the King Catholic School and the financial institution a reasonable opportunity to act on it.

Name of Financial Institution	Checking or Savings	Bank Routing Number	Bank Account Number

Indicate date of monthly ACH withdrawal: 15th of each month* $_____, starting _____

Note: Family accounts will be assessed a $25.00 fee on return ACH for non-sufficient funds. ***$20.00** late fee will be charged to family accounts for NSF-15th ACH no exceptions.

Account Holder Signature Date

Joint Account Holder Signature Date

For Christ the King Catholic School to verify bank account and routing numbers, account holders should attach a **VOIDED CHECK** for the account holder account that is to be debited. Christ the King Catholic School and account holders should retain completed copies of this form for their records.

Place VOIDED CHECK Here

NOTE: If withdrawal date falls on Saturday, your funds will be withdrawn on Friday.
If withdrawal date falls on Sunday, your funds will be withdrawn on Monday.