**COMET CARE -REGISTRATION FORM**

**SCHOOL YEAR: 2016-20017**

TODAY’S DATE :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CHILD’S FULL NAME** | **AGE** | **DATE OF BIRTH** | **SCHOOL** | **GRADE** | **TEACHER** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

CHILD LIVES WITH: \_\_\_\_\_\_BOTH Parents \_\_\_\_\_\_\_Mother \_\_\_\_\_\_\_Father \_\_\_\_\_Others (­­­\_\_\_\_\_\_\_\_\_)

**PARENT/GUARDIAN INFORMATION**

|  |  |  |
| --- | --- | --- |
| **PARENT/GUARDIAN INFORMATION** | **ADDRESS** | **PHONE** |
| **Mother:** | **Mother:** | **Mother:** |
| **Father:** | **Father:** | **Father:** |
| **Mother’s Place of Business** | **Address:** | **Phone:** |
| **Father’s Place of Business** | **Address:** | **Phone:** |

**EMERGENCY PHONE CONTACTS: List individuals OTHER than the child’s parents available DURNING PROGRAM HOURS. Parents will always be contacted first.**

|  |  |
| --- | --- |
| **NAME** | **PHONE NUMBER(S)** |
|  |  |
|  |  |
|  |  |
|  |  |

**PARENT EMAILS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**THE FOLLOWING ADULTS HAVE PERMISSION TO PICK UP MY CHILD FROM COMET CARE (INCLUDE PARENTS’ NAMES):**

|  |  |  |
| --- | --- | --- |
| **NAME** | **PHONE** | **RELATIONSHIP TO STUDENT** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**The below individuals are NOT permitted to pick up my child**

**(court documents must be provided)**

|  |  |
| --- | --- |
| **NAME** | **RELATIONSHIP** |
|  |  |
|  |  |

|  |
| --- |
| **COMET CARE PROGRAM**  **FINANCIAL OBLIGATION STATEMEMNT**  **By signing below, I accept full responsibility for all scheduled payments and fees incurred during participation in the Comet Care Program.**  **Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_**  **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\*If parents divide financial obligations for the enrolled child, the person signing above accepts responsibility for all fees and payments in total.** |

**COMET CARE- PROGRAM SELECTION FORM**

**REGISTRATION FEE: $50.00 (per family; non-refundable)**

**List below each child’s FULL NAME and check the appropriate box for the program(s) your child is to be enrolled in.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Child’s FULL NAME** | **AM ONLY** | **PM Only** | **FULL Program (AM & PM)** | **DROP-IN**  **SERVICE (Voucher Required)** | **HALF DAYS** | **What days during the week?** |
|  |  |  |  |  |  | **M T W T F**  **Please circle** |
|  |  |  |  |  |  | **M T W T F**  **Please circle** |
|  |  |  |  |  |  | **M T W T F**  **Please circle** |
|  |  |  |  |  |  | **M T W T F**  **Please circle** |

**NOTE: IF your child enrolls in the AM, PM, or FULL program but needs additional child care on HALF DAYS (2.25 hours), check the appropriate box above labeled “+ Half Days.”**

|  |
| --- |
| **Rutgers Child Care Assistance Program (CCAP)**  **If you will be filing for child care subsidy assistance, your signature below authorized COMET CARE to provide CCAP with the necessary information for benefit amount determination. Also, you agree to comply with mandatory DAILU attendance procedures and be responsible for ALL scheduled tuition co-payments (if applicable) to the Comet Care Program.**  **Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_**  **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Completed registration forms along with a $50.00 non-refundable, can be submitted via online or mailed in:**

[**www.cometcare.com**](http://www.cometcare.com)

**Comet Care**

**PO Box 631**

**Swedesboro, NJ 08085**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex:\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. Medical History: Check ALL that apply to your child | | | | | |
|  | Asthma |  | Frequent Nose Bleeds |  | Pneumonia |
|  | Hay Fever |  | Tubes in Ears |  | Tonsillitis |
|  | Diabetes |  | Rheumatic Fever |  | Frequent Sore Throats |
|  | Bleeder |  | Tires Easily |  | Frequent Ear Aches |
|  | Heart Disease |  | Frequent Headaches |  | Frequent Colds |
|  | Seizure or Spells |  | Frequent Stomach Aches |  | Hoarseness |
|  | Bone Disease |  | Poor Appetite |  | Mouth breather |
|  | Vision Problems |  | Frequent Urination |  | Speech Difficulty |
|  | Skin Problems |  | Clumsiness |  | Convulsions w/high fever |
|  | Eczema |  | Dental Problems |  | Fainting Spells |
|  | Hearing Problem |  | Color Blindness |  | Physical Handicap |

1. Insect sting allergy \_\_\_\_\_\_\_\_\_YES \_\_\_\_\_\_\_\_\_\_NO
2. Food Allergy\_\_\_\_\_\_\_ YES \_\_\_\_\_\_\_\_\_\_NO \*If YES, what food(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe the allergic reaction \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. \_\_\_\_Allergic reaction is a local one with swelling, requiring the application of ice.
2. \_\_\_\_ Allergic reaction is a severe local one with swelling requiring medical attention (In this case parent/guardian will be contacted).
3. \_\_\_\_ Allergic reaction is a life-threatening systemic reaction requiring immediate medical attention (In this case emergency care will be summoned, parent and guardian contacted.) Epi-pen will be administered if an anaphylactic reaction occurs, providing an Epi-pen and letter of permission to administer is provided by parents, along with a physician order to administer the Epic-pen.

**I hereby give permission for child to be taken to \_\_\_\_\_\_\_\_­­­­­­­­\_\_\_\_\_\_\_\_\_\_hospital in case of emergency when unable to contact an authorized person or guardian.**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**PARENTAL AUTHORIZATION AND CONSENT**

**Photo/Video Consent:** I consent that photographs and videos taken of my child are the property of the Comet Care and may be reproduced and publicized as the Comet Care desires, free of any claims on my part. If I do not wish for my child to be photographed or videotaped I will notify the business office in writing.

**Medical Emergency:** I give consent to have my child receive first aid by the child care staff, and, if necessary, be transported to receive emergency care. I authorize representatives from the Comet Care to give consent for any and all necessary emergency medical care for my child and I understand that I will be responsible for all charges not covered by insurance.

**PARENTAL AGREEMENT**

* I have received the Comet Care Parent Handbook and understand that it is my responsibility to follow Parent Handbook policies and to make sure my child understands the rules and regulations of the program.
* I understand that staff protects themselves and the Comet Care by agreeing not to be alone with Comet Care youth or program participants outside of Comet Care programs. This includes, but is not limited to, no babysitting, transporting children at any time, or having contact with Comet Care during non-program hours.
* I understand and agree that my child is not permitted to bring toys, playing cards, video games, or any non-school items to the Comet Care, and understand that if they do so, they will be taken and given to parents at the time of pick up.
* I understand that the Comet Care is not responsible for any personal belongings that are lost, stolen or damaged
* I understand that my child care payments are due by the 20th of each month, and that payments received after the 25th will accrue a late fee charge. I understand that if payment is not received by the last day of the month, services for that month are treated as a withdrawal from the program. I understand that re-admittance into the program will require another registration fee
* I understand that the Program must be provided a copy of all appropriate legal paperwork when the custodial parent requests the Program not to release the child to the non-custodial parent.
* I understand that my child will not be admitted to the program until all required documents have been received.

Authorized Parent’s Signature: ­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***I attest that all of the information in this packet is accurate and that I have received, read and understand the following policies listed in the parent handbook:***

1. Information to Parents statement prepared by the Bureau of Licensing
2. Policy on the Release of Children
3. Policy on Discipline and Discipline Agreement (has been read and discussed with my child)
4. Policy on Administering Medicine/Health Care Procedures/Management of Communicable Diseases
5. Comet Care Code of Conduct (has been read and discussed with my child)
6. Policy on the Expulsion of Children from Enrollment
7. Late Pick-up Policy

Authorized Parent’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* If it becomes necessary to close school early or cancel after school activities after the school day has begun, Comet Care will also be cancelled. The district emergency phone system will activate. This for will help the school staff to dismiss your child in the appropriate manner to which you have requested.
* In the event of an early school closing, my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_will:
* \_\_\_\_\_\_\_\_\_\_\_\_\_ Take their regular bus home.
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Be picked up at the school by an authorize person.

**Anyone picking up from school must enter the building to sign the child out and must also be listed with the school as an authorized escort. If you are late, the emergency contact number will be called.**

**Updated 6/23/16**