PARENT RECEIPT OF INFORMATION:
PLEASE CHECK BOXES

- ☐ Information to Parents Document
- ☐ Policy on the Release of Children
- ☐ Positive Guidance and Discipline Policy
- ☐ Policy on Methods of Parental Notification
- ☐ Policy on Communicable Disease Managment
- ☐ Expulsion Policy
- ☐ Policy on the Use of Technology and Social Media

I have read and received a copy of the information/policies listed above.

Child's Name (Each child will need a separate form):

____

Parent/Guardian's Name: ______________________

*Signature:*_________________________ *Date:*__________

COMET CARE -REGISTRATION FORM
SCHOOL YEAR: 2019-2020

ENROLLEMENT DATE :______________________________

CHILD'S FULL NAME	AGE	DATE OF BIRTH	SCHOOL	GRADE	TEACHER

*******You must fill out separate forms for each child that will be registered*******

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. All payments are due on the 20th of each month.

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 single child or $75.00 per family (non-refundable)

List below your 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)	What days during the week?
	☐	☐	☐	M T W T F Please circle

ADDITIONAL CHILDREN ENROLLED IN THE COMET CARE PROGRAM: This information helps with tuition payment

Child's FULL NAME	AM ONLY	PM Only	FULL Program (AM & PM)	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

WHEN PAYING BY PAYPAL, WHAT NAME WILL IT BE UNDER:____________________

STATE ASSISTANCE ONLY 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. There will be a $3 a day fee for not swiping and filling out a discrepancy form. YOU MUST SWIPE DAILY.

Printed Name: ________________________________ Date: __________

Signature: ____

Completed registration forms along with a $50.00 (one child) or $75.00 (family) non-refundable, can be mailed in:

Comet Care
PO Box 631
Swedesboro, NJ 08085

Name: ________________________________ **Grade:**_____________

Insect sting allergy _________YES __________NO

Food Allergy_______ YES __________NO *If YES, what food(s)?____

A. 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

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:** ____________

MEDICAL DECLARATION STATEMENT FOR SCHOOL-AGED CHILD CARE

Child's Name:______________________________ Date of Birth:_____________

Is your child under any medical/physical restrictions: Yes_______ No_________

In order for our staff to assure your child a happy, meaningful experience at our program, please share any special needs your child may have (i.e. learning disabilities, limitations, etc.)

____

____

____

Is your child taking any medications: Yes____________ No___________

If yes, please list:

____

____

____

____

Has your child been under a doctor's care or hospitalized within the last 3 years: Yes___ No________

If yes, please explain:

____

____

Is your child allergic to any medications/foods/insect bites: Yes __________ No ________

If yes, please explain:

____

____

As a parent/guardian of the above participating child, I certify that he/she is in good physical health, has no special needs, except as noted above, and may participate in all the activities of the Comet Care program. In the event of an emergency (accident/illness) during the Comet Care program that needs immediate treatment, I agree to my son/daughter to receive first aide and medical treatment from qualified staff members. I also authorize the transportation of my child by ambulance if necessary to ________________ or the nearest available medical facility.

PARENT/GUARDIAN SIGNATURE:____

DATE:____

CHILD'S PHYSICAN INFORMATION

Date:_______________________________________

Child's Name:____

Child's Primary Medical Provider:____

Phone Number:____

Address:____

Other Medical Provider (if needed):____

Child's Insurance Provider:____

Group Number:____

ID Number: ____

Name of Insurance Holder:____

Medical conditions that may interfere with learning: YES___________________ NO_________________

If yes, please explain:

____

____

____

As a parent/guardian of the above participating child, I certify that he/she is in good physical health, has no special needs, except as noted above, and may participate in all the activities of the Comet Care program. In the event of an emergency (accident/illness) during the Comet Care program that needs immediate treatment, I agree to my son/daughter to receive first aide and medical treatment from staff members. I also authorize the transportation of my child by ambulance if necessary to ______________________ or the nearest available medical facility. The undersigned parent or legal guardian assumes all risk of injury or harm to the child while the child is at the Comet Care center. The parent or legal guardian agrees to fully release, indemnify, and discharge Comet Care, its owners, staff, employees, and agents of and from all liability, claims, demands, damages, costs, expenses, actions, and causes of action in respect of death, injury, loss, or damage to the child, or by the child, howsoever caused, arising out of or to arise by reason of or during the child's participation in Comet Care.

Parent Name:____ Date:___________________

Parent Signature:____

COMET CARE 2019-2020

PARENTAL AGREEMENT FOR MEDICAL POLICY, RELEASE POLICY, AND THE INFORMATION TO PARENTS STATMENT

I have received a copy and understand the Medical Policy, Release Policy, and the Information to Parents statement prepared by the Office of Licensing, Child Care & Youth Residential Licensing, in the Department of Children and Families.

By signing this you are stating that you read and understand each policy. If you have any questions, please call the main office at 609/922-9353 or email info@cometcare.com.

Parent name: ______________________________ Parent 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 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: __________

Emergency Closing/Delayed Opening

When school is cancelled for the entire day due to inclement weather or other emergencies, the Comet Care Program will also be closed. **If a delayed opening is called, Comet Care will also be delayed IF staff is available **Please note that most of the staff members are college students and have class scheduled during school hours. Comet Care doesn't require staff to miss their scheduled classes outside the normal Comet Care hours **** If there isn't enough staff for a delayed opening, there will be no Comet Care AM. If staff is available and Comet Care does go forward with a delayed opening, Comet Care will open at 9:00 am instead of 7:00 AM. The district's Emergency Phone System along with the REMIND app will notify you if there is a delayed opening. Information regarding closings will also be posted on our Web Site.

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 Comet Care 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
8. Emergency Closing/Delayed Opening

Authorized Parent's Signature: ____________________________ Date: __________

Print Name: ______________ Child's Name: ______________________________

Updated 5/1/2019