

CREC Magnet Schools—Reggio Magnet School of the Arts 2017-18 Before/After Care Application

Please complete this form and return to Amelia Moffat.

Registration Information:

Please contact the program coordinator for any concerns regarding your child(ren). We do not have access to school files.

Check		Date
_____	New Registration: Student(s) will begin participation on	_____
_____	Change in scheduled hours of participation. Changes will begin on	_____
_____	Student(s) will no longer participate in Before/After Care program as of	_____

Student Information:

Student Name(s)	Date of Birth	Grade	Teacher	M/F	Allergies

Parent/Guardian Information:

Parent/Guardian Name:		Relationship:
Address:		Student lives with (YES or NO)
Home phone:	Cell phone:	Work phone:
Employer and address:		
Email address:		

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Emergency Contacts/Authorized to Pick Up:

(Please note that for the safety of your child(ren), we will not release them to any person not on this list)

Name	Relationship	Cell Phone	Work/Home Phone

Student Name(s): _____

Hours and Costs: Indicate your selection below. All fees are per child.

Description	Per Week (for 36 weeks)	Per Month (for 10 months)	Annually	Y / N
Before Care	\$30	\$108	\$1,080	
After Care	\$75	\$270	\$2,700	
Before And After Care (10% discount for student in both Before and After Care)	\$94.50	\$340	\$3,402	

Parent/Guardian Acknowledgement:

- (Hartford Families Only)** I would like my child to take the evening bus from Reggio to their assigned Hartford After Care bus stop. (For Hartford students in grades K-5)
- I understand that my child is expected to participate fully in the program and maintain expected school behaviors.
- I understand that I will be responsible to pick up my child from After Care in the case of illness. Sick students will not be transported home on the bus.

I/we have read, understand and agree to adhere to all of the policies, procedures and expectations outlined in the Reggio Magnet School of the Arts Before/After Care Family Handbook.

I/we agree to pay all fees owed on a WEEKLY or MONTHLY (circle one) basis.

In the event of an emergency, I/we authorize my/our child(ren) to be treated at the nearest hospital.

Child's Primary Care Physician: _____ Phone number: _____

Parent/Guardian Name (please print)	Parent/Guardian Signature	Date

The following is for federal and state reporting purposes only:

Ethnicity (circle one)	American Indian	Asian	Black, not of Hispanic origin	Hispanic	White, not of Hispanic origin
What language did the student(s) learn to speak first?					
What is the primary language spoken by parents/guardians or other persons living in the student's home?					
What is the primary language spoken by the student(s) at home?					