



Resurrection Catholic School After School Program (ASP)

ASP important information

- Begins the first day of school (Monday, August 29)
- Children from grades Pre K to 8 may attend
- Daily snacks and drinks provided
- Homework time provided
- On weather dismissal days the ASP will be CLOSED. Please make other arrangements.
- Fighting, disrespect and bad language is not acceptable. After the third warning the child will be suspended from the program.
- Toys, trading cards, electronics, etc. may not be brought from home

Cost

- \$4 per hour per child
- Cost is set up hourly and not broken down into quarter or half hours
- Billing cycle begins at 3:00pm
- A late fee of \$5.00 per 10 minutes added if child not picked up by 6:00pm
- ASP bill **must** be paid promptly.

Registration

- Students must be registered to attend the ASP, all forms must be on file prior to start date
- Fill out the attached paperwork, medical forms must be completed by a physician

Please contact the principal if you have any questions or concerns.
717-392-3083 or jhughes@rcspa.org

**Resurrection Catholic School
After School Program Registration**

Name and grade of each child registering for the ASP

Parent/Guardian information

Address _____

Home phone _____ Cell phone _____

Employer's name and phone number

Emergency contact people

Name _____ Phone _____

Name _____ Phone _____

In case of an emergency my child may be taken to Lancaster General -Penn Medicine Hospital for treatment.

Parent/Guardian Signature

Pick-up information

Approximate time you will pick up your child _____

The following people have your permission to pick-up your child/ren at the ASP.

Name _____ Relationship _____

Name _____ Relationship _____

I hereby agree that my child/ren will comply with all the rules and regulations of the Resurrection After School Program.

Parent/Guardian Signature

Date

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST) (FIRST)		PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	
		WORK PHONE:
☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.		
PARENT'S SIGNATURE:		

DO NOT OMIT ANY INFORMATION
This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)
☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)

HEARING (subjective until age 4)

LEAD

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/DT						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:

SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT

ADDRESS:

TITLE:

PHONE:

LICENSE NUMBER:

DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.

AGREEMENT

55 PA CODE CHAPTERS 3270.123 & .181(c); 3280.123 & .181(c); 3290.123 & .181(c)

NAME OF CHILD		
FEE AMOUNT \$	PER-DAY-WEEK	DAY PAYMENT TO BE MADE
Services to be provided as part of the day care fee (examples; transportation, care, meals, etc.)		
CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
LATE FEE \$	PER MIN-HR	
Extra services to be provided at an additional fee if applicable		

I, the parent/guardian;

☐ received complete written program information at the time of enrollment (§ 3270.121, 3280.121, 3290.121)

☐ agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minimum. (§ 3270.124, 3280.124, 3290.124)

SIGNATURE-OPERATOR

DATE

SIGNATURE-PARENT OR GUARDIAN

DATE

DATE OF CHILD'S ADMISSION

DATE OF WITHDRAWAL

PERIODIC REVIEW

SIGNATURE-PARENT OR GUARDIAN

DATE

3

EMERGENCY CONTACT / PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124(a)(b), 3270.181 & 182; 3280.124 (a)(b), 3280.181 & 182; 3290.124 (a)(b), 3290.181 & 182

CHILD'S NAME		BIRTHDATE
ADDRESS		
MOTHER'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER
ADDRESS		
BUSINESS NAME		BUSINESS TELEPHONE NUMBER
ADDRESS		
FATHER'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER
ADDRESS		
BUSINESS NAME		BUSINESS TELEPHONE NUMBER
ADDRESS		
EMERGENCY CONTACT PERSON(S)	NAME	TELEPHONE NUMBER WHEN CHILD IS IN CARE
PERSON(S) TO WHOM CHILD MAY BE RELEASED	NAME	ADDRESS
		TELEPHONE NUMBER WHEN CHILD IS IN CARE
NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER		TELEPHONE NUMBER
ADDRESS		
SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTION)	
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICATION, SPECIAL CONDITIONS	
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD		
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS		POLICY NUMBER (REQUIRED)
PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT		
OBTAINING EMERGENCY MEDICAL CARE	ADMIN. OF MINOR FIRST - AID PROCEDURES	
WALKS AND TRIPS	SWIMMING	
TRANSPORTATION BY THE FACILITY	WADING	
PERIODIC REVIEW		

SIGNATURE OF PARENT or GUARDIAN

DATE

SIGNATURE OF PARENT or GUARDIAN

DATE