



Regworks mealsheet sisk12 (course & fees) Class List

School: _____

Fall 2020 School Age Childcare Coversheet

EVANSTON/SKOKIE SCHOOL DISTRICT 65

Every Child, Everyday Whatever It Takes



◇ To Fees _____

Date	Steps completed
	Received (in person / email / fax)
	Reviewed
	To Fees

Grade: _____

District 65 ID: _____ Start Date: _____

Last:	_____
First:	_____
Middle:	_____

◇ new sibling _____

returning sibling _____

Registered in District 65 Schools?

Yes @D65 Student Registration Date: _____

No, D65 school registration must be completed in order to begin child care

Fee Status

****Note: \$50 non-refundable reg. fee added for 1st child & \$25 for each additional child****

Full Fee

Certificate

Other

* If fees were paid via D65 EPay - Transaction #: _____ Amt. paid: _____ date processed: _____

Session Status

fees subject to change

revised 1/29/20

webpage

Regular Session (circle one)	Subsidy Add-on	*New* 3 (consistent) Days Only	Circle Consistent 3 days needed	(5 Days) 2 Week Full Fee
AM	\$0.00	\$56.00	M T W Th F	\$80.00
PM	\$0.00	\$112.00	M T W Th F	\$160.00
BOTH	\$80.00 (add-on)	\$168.00	M T W Th F	\$240.00

bi-monthly fees

bi-monthly fees

bi-monthly fees

Optional Care Program

Paid Yes (check each that applies)

\$450 for all 9 (OPT) days

\$350 for 7 (HALF days)

\$200 for 2 (FULL) non-attendance days

No Thanks

Check to sign up for emergency care (\$20 per child/session)

**All childcare fees are based on enrollment not attendance
Fees are due in advance of care according to our center's current payment schedule (initial) _____**

SACC fees can be paid a variety of ways at 1500 McDaniel Ave (No payments are accepted at each school):

- * To start the first day of school, all SACC registration documents & payment #1 needs to be received at our SACC JEH office (1500 McDaniel Ave) by 8/14 *
- You can pay via auto pay by individually setting autopay up through your bank or another financial institution
- Via payment agreement (initial fees and/or ongoing D 65 auto-pay); contact Clara Estrella at 847-859-8015 or estrellac@district65.net for more details.
- Online registration (<https://district65.revtrak.net>) and in addition DCFS requires that we receive an annual packet of documents to our offices at JEH
- Mail to Evanston School District 65 SACC Fees, Attn: Clara Estrella, Business Office, 1500 McDaniel Ave, Evanston IL 60201
(Reference your child(ren)'s first and last name or D 65 ID# on the memo line).
- Checks, money orders, credit Card (visa/master card) & cash payments are also accepted in person at 1500 McDaniel Ave.

I understand Opt Care fees are non-refundable and are initially due prior to participation in the service (initials) _____

~The Optional Care fee is waived for approved D65 certificate families during approval period only.

Subsidy Status: D65 must be listed as a provider on the current approval otherwise regular fees must be paid until updated approval is received

Who is responsible for payment of fees? Name: _____ Day Phone: _____

I agree to make payments via check, credit card, cash or money order according to the District 65 Child Care Payment Schedule.
I understand if my payments are not received in the Child Care office by the due dates.

I'm responsible for the applicable late payment fee and my child care services may be cancelled.

Parent Signature: _____

Print Name: _____

Date: _____

Preferred email for communications (Please print clearly) : _____

Rev. 1/22/2020

* A new **USDA/CACFP enrollment form** is required each year to complete the SACC registration packet.
This form is normally available after July 1st of the school year and can be downloaded and completed from our website each year.



Parent A										Parent B				
Parent Name:														
Best Contact Number (cell, home, work):														
Organization/Occupation:														
Working Hours:														
Preferred Email:														
Child's Name as listed on birth certificate	Scheduled Start Date	Birthdate	Age	Identify as:	Current School Name	Child in Special Ed?	Entering Grade	3 Days Only (circle days)	Session					
Last:				M	School Attended Last Yr	Yes or No	K 1	M T W T H F	AM					
First:	Return date:			Non Binary		Phs or Beh	2 3	M T W T H F	PM					
Middle:	End Date:			F		Rice Park MS	4 5	M T W T H F	BOTH					
District 65 ID #:						1-1 IEP? Y or N	No 6th Grade	OPT 1/2 F	OPT 1/2 F					
Child's Name as listed on birth certificate	Scheduled Start Date	Birthdate	Age	Identify as:	Current School Name	Child in Special Ed?	Entering Grade	3 Days Only (circle days)	Session					
Last:				M	School Attended Last Yr	Yes or No	K 1	M T W T H F	AM					
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Middle:	End Date:			F		Rice Park MS	4 5	M T W T H F	BOTH					
District 65 ID #:						1-1 IEP? Y or N	No 6th Grade	OPT 1/2 F	OPT 1/2 F					

[Handwritten Signature]

By signing below you are also agreeing that:
In case of an emergency, when parent or family physician cannot be contacted, I give District 65 Child Care personnel permission to take whatever action is deemed necessary to ensure my child's health and safety. I will accept responsibility for any expenses incurred.

Parent Signature: _____ Date: _____
rev 1/22/20 Print Name: _____



SACC PAYMENT AGREEMENT 2020 -21

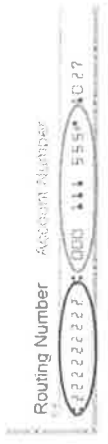
Please **initial** applicable section, fill out information as needed, and sign agreement below:

- _____ I authorize Evanston/Skokie School District 65 to auto debit the school age childcare registration fee of 50.00 and initial payment 1 with the credit card listed below.
- _____ I authorize Evanston/Skokie School District 65 to auto debit the school age childcare registration fee of 50.00 if applicable and set my childcare payments for auto pay with the credit card listed below for all remaining childcare payments (2-19) for the 2020-21 school year according to the payment schedule.
- _____ I authorize Evanston/Skokie School District 65 to auto debit the school age childcare registration fee of 50.00 plus the optional care package fee selected on my registration cover sheet.

Checking Account

Checking

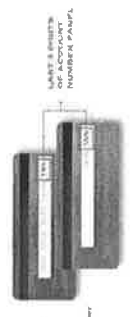
Name on Acct _____
 Bank Name _____
 Account Number _____
 Bank Routing # _____
 Bank City/State _____



Credit Card

Visa MasterCard Discover

Cardholder Name _____
 Account Number _____
 Exp. Date _____
 3 Digit Security Code _____



Total payment processed for start: _____

Agreement:

1. I understand that I am responsible to notify the Evanston/Skokie School District 65 immediately if credit card information changes.
2. I understand that these financial arrangements will remain in effect until:
 - a. The total amount due is collected by Evanston/Skokie School District 65.
 - b. I have requested in writing a cancellation of the program and have paid all current fees, or
 - c. The Evanston/Skokie School District 65 or my financial institution sends me a notice of termination of this agreement.
 - d. Auto payment will be applied in accordance to the school age childcare payment schedule and will continue accordingly beginning with payment 1 through payment 19 for the entirety of the school year. Payments will be applied on a biweekly basis unless cancelled or childcare has been temporarily suspended by parent for a consecutive period of time according to the school age childcare monthly schedule.
3. I have read and agree to comply with the 2019-20 school age childcare payment information shared on this form and the school age childcare registration form.
4. I understand that any declined payment will incur a 25.00 service fee.
5. Childcare Care cancellation must be made in writing with notice at least 5 business days prior to the start of school. All other cancellation must be made at the end of the school age childcare billing cycle according to the 2019-20 payment schedule which will be provided during registration with the exception of kindergarten registration.
6. Once the program has started, no prorated fees will be given for partial month's attendance or early withdrawals.

SIGNATURE: _____

DATE _____

School Age Child Care
Evanston/Skokie School District 65
1500 McDaniel Ave.
Evanston, IL 60201
847-859-8300
847-866-7259 (Fax)



EVANSTON/SKOKIE
SCHOOL DISTRICT 65

Every Child, Every Day, Whatever It Takes

GETTING TO KNOW YOU

CHILD CARE SITE:

NAME _____ AGE ____ NUMBER OF SIBLINGS: _____

Child's favorite toy/game/activity

What is the best way to get acquainted with your child?

How does your child show his/her feelings when angry or happy?

If upset, what is the best way to calm and/or comfort your child?

In general how is discipline handled at home?

Do you have any suggestions/hints for our staff that may help us be more successful with your child(ren)?

Has your child participated in another Child Care Program? Yes No

Medical History

Does your child(ren) have any medical conditions Yes No

If yes, please explain & give pertinent information (medications etc)

Does your child(ren) have any allergies or sensitivities? Yes No

If yes, please explain & give pertinent information (medications, Epi-Pen etc)

Parent Signature

Date

School Age Child Care

Evanston/Skokie School District 65

1500 McDaniel Ave.

Evanston, IL 60201

847-859-8300

847-866-7259 (Fax)



**EVANSTON/SKOKIE
SCHOOL DISTRICT 65**

Every Child, Every Day, Whatever It Takes

School Age Child Care Program

Parent Pick-up Release Form

Child's name

Site

Note: Children will not be released to minors. The pick-up person must be at least 18 years old with a valid I.D. Please complete all the information requested in the space below.

I GIVE PERMISSION FOR THE FOLLOWING ADULTS TO PICK UP MY CHILD(REN):

- | | | | |
|----|-------------|----------------|--------------------|
| 1. | _____ | _____ | _____ |
| | Name | Address | Cell/Work# |
| 2. | _____ | _____ | _____ |
| | Name | Address | Cell/Work# |
| 3. | _____ | _____ | _____ |
| | Name | Address | Cell/Work # |

Is your child under a court order of protection? **Yes** **No**
If yes, a copy of court document must be provided/attached.

Parent Signature

Date

Charlotte Carter
School Age Child Care Coordinator

School Age Child Care

Evanston/Skokie School District 65

1500 McDaniel Ave.

Evanston, IL 60201

847-859-8300

847-866-7259 (Fax)



**EVANSTON/SKOKIE
SCHOOL DISTRICT 65**

Every Child, Every Day, Whatever it Takes

CHECKLIST

I understand that due to state licensing requirements; Child Care (SACC) staff cannot accept sack lunches as a substitute for providing meals. I shall provide a written confirmation from my doctor if my child requires a substitution. **Initials** _____

I have received the DCFS Summary of Licensing Standards for Day Care Centers.
Initials _____

I have reviewed online at www.district65.net Rules for Student Behavior and School Discipline and the SACC Guidance and Discipline policy. I have will ensure my child(ren) fully understand how this information pertains to them while in our care. **Initials** _____

I have reviewed and understand the SACC late pick-up process and policy. **Initials** _____

I grant permission for my child(ren) to be photographed/videotaped and interviewed while participating in SACC activities or on field trips. **Initials** _____

My signature confirms I have read the statements above in addition to reviewed the current SACC Parent Handbook (online and/or hard copy).

Signature of Parent/Guardian

Date

Dear Parent/Guardian:

If it is necessary for your child to take medication at school, you must read and complete the following form:

Medicine can only be given by school personnel if ordered by a physician. Medication ordered by a physician or labeled by a pharmacist needs only a parent request (part 1). Request to give over the counter medication or to have a child carry their medications must be accompanied by a signed request from both the physician and the parent/guardian (parts 1 and 2).

PARENTAL MEDICATION REQUEST

I HEREBY CONFIRM MY PRIMARY RESPONSIBILITY TO ADMINISTER MEDICATION TO MY CHILD. HOWEVER, IF MY CHILD MUST RECEIVE MEDICATION WHILE IN SCHOOL, I AUTHORIZE SCHOOL DISTRICT 65 AND ITS EMPLOYEES TO ADMINISTER LAWFULLY PRESCRIBED MEDICATION TO MY CHILD. I ACKNOWLEDGE THAT IT MAY BE NECESSARY THAT THE ADMINISTRATION OF MEDICATIONS TO MY CHILD BE PERFORMED BY A HEALTH CLERK OR OTHER INDIVIDUAL WHO IS NOT A CERTIFIED SCHOOL NURSE AND SPECIFICALLY CONSENT TO SUCH PRACTICES. I FURTHER ACKNOWLEDGE AND AGREE THAT, WHEN THE LAWFULLY PRESCRIBED MEDICATION IS SO ADMINISTERED OR ATTEMPTED TO BE ADMINISTERED, I WAIVE ANY CLAIMS I MIGHT HAVE AGAINST THE SCHOOL DISTRICT AND ITS EMPLOYEES AND AGENTS ARISING OUT OF THE ADMINISTRATION OF SAID MEDICATION. IN ADDITION, I AGREE TO HOLD HARMLESS AND INDEMNIFY THE SCHOOL DISTRICT AND ITS EMPLOYEES FROM AND AGAINST ANY AND ALL CLAIMS, DAMAGES, CAUSES OF ACTION OR INJURIES INCURRED OR RESULTING FROM THE ADMINISTRATION OR ATTEMPTS AT ADMINISTRATION OF SAID MEDICATION.

I WILL NOTIFY THE SCHOOL OF ANY CHANGE IN MEDICATION OR DOSAGE AND WILL SEND THE SCHOOL A WRITTEN ORDER FROM THE DOCTOR WHEN A CHANGE IS NECESSARY.

PART 1

I HEREBY REQUEST THAT SCHOOL PERSONNEL ADMINISTER THE FOLLOWING MEDICATION(S) TO:

	NAME OF CHILD			
1.	MEDICATION	DOSAGE	TIME	START & STOP DATES
2.	MEDICATION	DOSAGE	TIME	START & STOP DATES

PARENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

PART 2

Physician's signature required for over the counter medications, child to carry medications, additional clarification, etc.
Requests/comments:

PHYSICIAN'S SIGNATURE _____ DATE _____ TELEPHONE NUMBER _____

MEDICATION FORM
EVANSTON/SKOKIE SCHOOL DISTRICT 65 - HEALTH SERVICES OFFICE

STUDENT NAME: _____ DOB: _____ SCHOOL: _____ GRADE: _____ YEAR _____
 MEDICATION: _____ TEACHER: _____ ROOM: _____ Ext. _____
 DOSE: _____ TIME: _____ EXP. DATE _____ DATE REC'D IN H.O. _____ # OF PILLS REC'D _____
 SPECIAL INSTRUCTIONS: _____

DATE OF MEDS RETURNED TO PARENTS: _____ PARENT INITIALS _____ HOP INITIALS _____

MEDICATION RECORD/ADMINISTRATION (FOR SCHOOL USE ONLY)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
AUGUST																															
SEPTEMBER																															
OCTOBER																															
NOVEMBER																															
DECEMBER																															
JANUARY																															
FEBRUARY																															
MARCH																															
APRIL																															
MAY																															
JUNE																															
JULY																															

CODES (USE FOR UNUSUAL SITUATIONS)
 A: ABSENT
 D/C: DISCONTINUED
 N: NONE AVAILABLE
 F: FIELD TRIP
 ED: EARLY DISMISSAL
 O: OMITTED
 R: REFUSED

NAME OF PERSON ADM. MED. _____ INITIALS _____
 NAME OF PERSON ADM. MED. _____ INITIALS _____
 NAME OF PERSON ADM. MED. _____ INITIALS _____