LASD 2024 Summer SACC Registration

Students Name: _____ M/F_____ Birthday: ___/___/____

Grade ***completed*** in June 2024: **Pre-K K 1 2 3 4 5 6 7**

Address: _____

City: _____ Zip Code: _____

Parent/Guardian Information:

1st Parent/Guardian: _____

(H)# _____ (C)# _____ (W)#_____

2nd Parent/Guardian: _____

(H)#_____ (C)#_____(W)#_____

Parent(s) Email Address

(1)_____

(2)_____

Emergency Contact(s):_____Phone:_____

Relationship: _____

Emergency Contact(s) **(Other than Parents)**:_____

Phone:_____ Relationship: _____

Authorized Pickups: **(other than parents)**

(1)_____

(2)_____

Password: _____

OFFICE USE ONLY: Registration received: ___/___/___ Payment received: ___/___/___

Payment: ___Cash ___Check #

Non refundable Registration Fee: $25.00 per family, payable to LASD SACC.

All forms must be returned by May 17th, 2024. Summer SACC is scheduled to begin on the first day of Summer Vacation and conclude on August 16th, 2024.

LASD 2024 Summer SACC Pricing

Student Price per Week	**$200.00**
Student Price per Day, 1-4 Days	**$50.00**

- Each invoice will be dated for the week of service and must be filled out prior to any child attending Kelly SACC that week.
- Non-excused absences will result in loss of payment. Any absences must be reported to the following phone number (570–524-0968), 24 hours in advance, or a valid doctor's note must be presented. (A non-excused absence for the program is defined as a student missing a day of care without a phone call being received ***or*** without a doctor's note not being presented).
- If a payment is made and a student is going on a vacation during the days paid for, a **three-day notification** must be made in order for credit to remain on student account.

You can either send the required paperwork, and payment in to school with your child, or send it to:

Leah Shaffer

1951 Washington Ave.

Lewisburg, PA 17837

570-522-3207…….shaffer_l@lasd.us

LASD 2024 Summer SACC
Service Agreement

Name of Child:

_____

Days of Service: MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY

Please indicate the day(s) you will MOST LIKELY need childcare.

Please summarize how often you will be expecting to use our summer camp.

Child's approximate arrival time	**Child's approximate departure time**	**Late fee** – after 6:00 pm $1.00 per minute

Services to be provided as part of the day care fee: Child care, breakfast, afternoon snack, transportation for field trips, fees for most local field trips (some field trips may have a small fee).

I, the parent/guardian:

- **Agree to pay the contracted fee if any non-excused absences occur**
- **Agree to notify LASD SACC in writing three days prior to my child being absent due to vacation plans; (***Loss of payment will result in any vacations not reported***)**
- **Agree to update emergency/parental consent form information whenever changes occur.**
- **Have received a handbook containing LASD SACC summer camp program information.**
- **Agree to pay the rates listed in the registration information**

Parent Signature: _____ Date ____/____/____

SACC Administrator: _____Date ____/____/_____

For student's new to our program, we also require a copy of your child's latest Doctors visit

****A print out from your Doctor is acceptable****

LASD 2024 Summer
SACC Health Update Form

Student's Name: _____

Birthdate: _____Gender: _____

Doctor's Name: _____ Phone # _____

List all medications allergies: _____

List all food allergies: _____

Has your child ever needed emergency treatment for an insect/bee sting? _____

Does your child need a Special Diet? _____

List any Illnesses/Health concerns of your child: _____

Is your child under medical treatment for any of the above? _____

Has your child been admitted to the hospital in the past year? _____

If yes, please explain: _____

List the year of any diseases, operations, or major injuries your child has had:

_____

Please list any medications your child takes at home: _____

Please list any medications your child will need to take at school:

_____

The above information is provided to ensure that my child will have a safe and healthy school experience. At times, confidential information may need to be shared with others on a need to know basis. I give permission for this information to be shared if necessary with emergency/hospital personnel, chaperones during school sponsored trips, teachers, bus drivers, administration, counselors, playground/cafeteria aides, coaches, and/or as needed with other school personnel involved with my child. (Please circle those whom may not receive health information.)

Parent Signature: _____ Date: _____

LASD 2024 Summer SACC
Emergency Form

Please update the form information and return to SACC

Student's Name: _____

Birthdate: _____ **Gender:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Parent/Guardian #1: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Parent/Guardian #2: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Parent Guardian #1 Phone# _____

Parent/Guardian #1 Employer: _____

Parent/Guardian #2 Phone # _____

Parent/Guardian #2 Employer: _____

If the school must contact a parent, please indicate first choice: _____

Emergency Contacts

In the event of an emergency or illness, the parent/guardian will be contacted first. Please list several other contacts, who can, in your behalf, discuss your child's health issues with school personnel, and/or can take your child home in the event that we cannot reach you.

Contact #1: _____ **Phone:** _____ **Relationship:** _____

Contact #2: _____ **Phone:** _____ **Relationship:** _____

Contact #3: _____ **Phone:** _____ **Relationship:** _____

Family Healthcare Provider/Physician: _____ **Phone #:** _____

Hospital of choice: _____

The above information can be shared in emergency situations, during school sponsored trips, or as needed with school personnel involved with my child. I give permission to the staff at Lewisburg Area School District to transport or to make arrangements for the transportation of my child to emergency care and to sign permission for treatment declared necessary immediately by a physician in the event that the persons above cannot be reached.

Parent/Guardian Signature: _____ **Date:** _____

Permission to Photograph

Students may be photographed during the LASD SACC summer camp program during field trips and camp activities. First names only would be used for identification of those photographed.

My child, _____, may be photographed for:

____ yes___no newspaper

____ yes___no internet (newspaper, district website)

____ yes___no LASD SACC flyers to announce camp for the next year

____ yes___no special events (field trips, camp activities)

Signature of Parent/Guardian: _____ Date: _____

Permission to Use Technology

_____I give permission for my child to have access to activities involving technology: including but not limited to educational software and the Internet. I also agree that my child will comply with the conditions of acceptable use and behavior regarding the use of technology. Should my child fail to comply with these conditions, I understand that his/her technology privileges at LASD SACC summer camp may be revoked.

_____I have decided that my child **will not** participate in the use of technology during LASD SACC summer camp.

Signature of Parent/Guardian: _____ Date: _____

LASD 2024 Summer SACC
Ambulance Permission Form

In case of an emergency, the LASD SACC program is required to have your permission to transport your child via ambulance.
Please complete the form below.

I, _____ give permission for my
Parent's Name

child, _____ to
child's name

be transported via ambulance to _____
Hospital name

hospital.

Waiver of Liability:

•I understand that during attendance, The SACC staff, volunteers, and affiliates will do everything they can to keep my child safe, however accidents do happen. In case of an accident or incident, I will not hold SACC, its staff, or its affiliates responsible for any harm that might come to my child.

•I understand that the SACC staff members are properly trained to handle emergencies and that if something should happen to my child the staff will use their best judgment in responding, and I will not hold them responsible for their judgments. I understand that these responses might include calling for emergency medical services, emergency medical treatment, going to the emergency room, or going to the doctor's office. I understand that I am responsible to pay for any expenses associated with these treatments. I give my permission for SACC to use whatever means necessary to treat my child in case of an emergency.

•I understand that I must adhere to all parent/ guardian rules at SACC. I am aware that failure to follow all rules can lead to termination of my child/ children's attendance privileges at SACC.

•I understand that SACC's primary responsibility is the safety of all students and staff members. I also understand that if at any time my child, or children are found to have instigated or caused an unsafe (emotionally or physically), or inappropriate situation, staff members have the right to ask my child to immediately leave the premises or program for any length of time and can place restrictions on returning to SACC.

Parent/Guardian Signature: _____ Date: _____

Shared Custody Situations:

Parent/Guardian Signature: _____ Date: _____

Illness/ Missed days:

•We understand that from time to time children become ill and need to stay home. We ask that you contact our office at (570) 524-0968, to inform us that your child (children) will not be in attendance that day. If a staff member is not available to take your call directly, please leave a message with the name of the child (children). We also like to ensure that all of our families are notified if there is a public health risk. Please advise us as to the illness your child (children) has. We will not share this information with other participants; we will simply inform families that we have been informed of a possible outbreak and that they should take certain precautions. If notified ahead of time, credit may be used for a sick day.

•If your child becomes ill, or arrives at SACC ill, (vomiting, diarrhea, and fever of 100 or more), then we will contact a parent or guardian for immediate pick up. The daily fee will be charged regardless of when the child leaves SACC.

Parent/Guardian Signature: _____ Date: _____

****Shared Custody Situations:

Parent/Guardian Signature: _____ Date: _____

2024 Summer SACC

SACC Payment Invoice, Week of: _____

Parent Name: _____

Childs Name: _____

Child's Name: _____

Child's Name: _____

Weekly:

Monday-Friday: $200.00 _____

Daily:

Monday: $50.00_____

Tuesday: $50.00 _____

Wednesday: $50.00_____

Thursday: $50.00_____

Friday: $50.00_____

Summer SACC Registration Fee: $25.00_____

Total Amount Paid: _____

Check# _____ Cash _____

*Please make checks out to: LASD SACC