



# Welcome to Extended Care!

## 2017-2018

*Monday through Friday*

**6:30AM - 6:00PM**

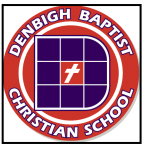
*The mission of Denbigh Baptist Christian School is to EDUCATE the mind, NURTURE the soul, and SHAPE the character of each student and staff member in a Christ-centered environment, based on the Truth of God's Word.*

We are so pleased and excited that you have decided to entrust your child's care to our responsible and dedicated staff. Below you will find E.C. options and fees for the current school year.

REGISTRATION FEE: \$25.00 PER STUDENT / \$50.00 MAXIMUM PER FAMILY			
Early Care 6:30AM - 8:00AM		After School Care 3:00PM - 6:00PM	
3 Day	5 Day	3 Day	5 Day
\$625	\$965	\$1,240	\$1,930
<b>Drop-in Daily Rate - \$6</b>		<b>Drop-in Daily Rate - \$13</b>	
Bundle Packages		3 Day	5 Day
Early Care + After School Care		\$1,640	\$2,480
<b>BUNDLE SAVES</b>		\$225	\$415

**Yearly Rates Can Be Divided Into 10 Monthly Payments**

**THIS CENTER IS EXEMPT FROM LICENSURE.**



# EXTENDED CARE (EC) APPLICATION

Denbigh Baptist Christian School adheres to a policy of admitting students of any race, color, nationality or ethnic origin to all rights, privileges, programs and activities generally accorded, or made available to students at the school. DBCS does not discriminate on the basis of race, color, national or ethnic origin in the administration of its educational, athletic, or any other policies or school-administered programs. However, DBCS reserves the right to refuse admission to, or dismiss, any student if they or their family profess, promote, or participate in a lifestyle that is contrary to the established teaching of Denbigh Baptist Church.

**Student's Name:** \_\_\_\_\_ Goes by: \_\_\_\_\_  
*Last First Middle*

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age:** \_\_\_\_\_ **Grade:** \_\_\_\_\_ **Sex (M/F):** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_  
*City State Zip Code*

## Family 1

**Father/Guardian** \_\_\_\_\_ **Mother/Guardian** \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

Cell # \_\_\_\_\_ Cell # \_\_\_\_\_

Home # \_\_\_\_\_ Home # \_\_\_\_\_

Work # \_\_\_\_\_ Work # \_\_\_\_\_

## Family 2

**Father/Guardian** \_\_\_\_\_ **Mother/Guardian** \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

Cell # \_\_\_\_\_ Cell # \_\_\_\_\_

Home # \_\_\_\_\_ Home # \_\_\_\_\_

Work # \_\_\_\_\_ Work # \_\_\_\_\_

Child's Physician \_\_\_\_\_ Office # \_\_\_\_\_ Preferred Hospital \_\_\_\_\_

Any Known Allergies \_\_\_\_\_

All ongoing prescription medications \_\_\_\_\_

Please give 2 contacts that can pick up your child in case of sickness, should both parents be unreachable:

Name/Relationship \_\_\_\_\_ Home# \_\_\_\_\_ Work# \_\_\_\_\_ Cell# \_\_\_\_\_

Name/Relationship \_\_\_\_\_ Home# \_\_\_\_\_ Work# \_\_\_\_\_ Cell# \_\_\_\_\_

Persons authorized to pick up your child \_\_\_\_\_

Persons NOT allowed to pick up your child \_\_\_\_\_

Please provide any other information regarding your child you would like us to be aware of \_\_\_\_\_



# EXTENDED CARE POLICIES

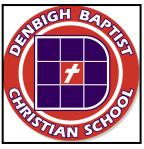
Hours of Operation 6:30 A.M. ~ 6:00 P.M.

**PLEASE READ THE FOLLOWING AND CHECK OFF EACH POLICY  
ACKNOWLEDGING THAT YOU UNDERSTAND AND AGREE**

1. \_\_\_\_\_ Before school, I will walk into the building with my child each day and make certain the teacher knows he/she is there. Others, including older siblings, may bring or pick up my child only with prior notice from a parent or guardian.
2. \_\_\_\_\_ At pick-up time, I, or those I have authorized, will walk into the building or to the playground gate and inform a teacher that I am leaving with my child.
3. \_\_\_\_\_ I need to pick up my child before closing time of 6:00 p.m. If I am late, I will pay an overtime charge of 5% for each 15 minutes, or portion thereof, after 6:00 p.m. I understand and agree that this fee is due at the time I pick up my child.
4. \_\_\_\_\_ I will inform the EC Center of changes in address, phone numbers, employment, emergency information, or any changes in family situations.
5. \_\_\_\_\_ My EC charges will be included on my monthly tuition bill. They fall under the same tuition policy as my tuition. EC charges cannot be carried over from month to month. My child is at risk of losing EC privileges, should I become delinquent.
6. \_\_\_\_\_ There is no reduction of fees during the school year for absences or vacations. Fees are reduced, however, for extended illness or periods when EC is closed for 2 or more days within the same week. Part-time fees apply for the remaining days of attendance.
7. \_\_\_\_\_ My E3, E4, or K5 child needs a complete change of clothing in a Ziploc bag. A personal rest mat will be provided by the EC Center. My child may bring a beach towel for rest time, if desired. Any child may bring a comb, brush, toothpaste, and a toothbrush with a cover, if desired. Please label each item with your child's name, including any jackets or sweaters.
8. \_\_\_\_\_ **I WILL KEEP MY CHILD HOME WITH THE FOLLOWING: FEVER, DIARRHEA, OR VOMITING WITHIN A PREVIOUS 24-HOUR PERIOD. THIS POLICY IS IN KEEPING WITH THE ESTABLISHED CLINIC POLICY IN THE DBCS HANDBOOK.** If my child is well enough to come to school, he/she will be expected to play outside at recess time, weather permitting.
9. \_\_\_\_\_ If, after a reasonable amount of time (to be determined by the Director), it is found that my child is unable to adjust to the Center, the EC Director reserves the right to request the withdrawal of my child.
10. \_\_\_\_\_ I understand that my E3 child can only attend EC on their school days... Mondays, Wednesdays, and Fridays.

\_\_\_\_\_  
*Parent's Signature*

\_\_\_\_\_  
*Date*



# EC SCHEDULE OF CARE

**Student's Name:** \_\_\_\_\_ Goes by: \_\_\_\_\_  
*Last First Middle*

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age:** \_\_\_\_\_ **Grade:** \_\_\_\_\_ **Sex (M/F):** \_\_\_\_\_

**Homeroom Teacher:** \_\_\_\_\_

Date of desired entrance: \_\_\_\_\_

Is this for occasional attendance only \_\_\_\_\_

**Please list your child's approximate arrival and departure times:**

	Arrival	Departure
Monday	_____	_____
Tuesday	_____	_____
Wednesday	_____	_____
Thursday	_____	_____
Friday	_____	_____

Child Accepted \_\_\_\_\_ EC. Billing to begin \_\_\_\_\_

Child withdrawn from program \_\_\_\_\_

\_\_\_\_\_  
Parent's Name Printed

\_\_\_\_\_  
Parent's Signature and date

\_\_\_\_\_  
Mrs. Sherri Landon, E.C. Director



# HEALTH INFORMATION FORM

This form must be completed each school year.

Student's Name \_\_\_\_\_  Male  Female

*Last First Middle*

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Student's Address \_\_\_\_\_  
*Street Address City State Zip*

Parents \_\_\_\_\_  
*Names Best Phone Number(s) in case of emergency*

## ALLERGIES

Allergy Type

- Food List food(s) \_\_\_\_\_
- Medication List medication(s) \_\_\_\_\_
- Bee Sting
- Other (List) \_\_\_\_\_

Reaction Type

- Mild  Severe Date of last severe reaction \_\_\_\_\_
- Coughing  Hives  Rash
- Difficulty Breathing  Local Swelling  Wheezing
- Generalized Swelling  Nausea  Other \_\_\_\_\_

Currently prescribed medications and treatments

- Oral Antihistamine (Benadryl, etc.)  Epinephrine  Other \_\_\_\_\_
- Medication needs to be given at school**

## ASTHMA

Triggers

- Exercise  Environmental  Other \_\_\_\_\_

Symptoms

- Difficulty breathing  Chest tightness, discomfort  Throat itch, tightness, or soreness
- Coughing  Hoarseness  Wheezing
- Other \_\_\_\_\_

Currently prescribed medications and treatments

- Inhalers  Oral antihistamines  Oral steroids
- Nebulizer  Other \_\_\_\_\_
- Medication needs to be given at school**

## DIABETES

Currently prescribed medications and treatments

- Insulin  Syringe  Pump
- Blood Sugar Testing  Glucagon  Other \_\_\_\_\_
- Oral Mediation (s) \_\_\_\_\_
- Medication needs to be given at school**

Continued on reverse



# Health Information Form continued

## SEIZURE DISORDERS

Type of Seizure \_\_\_\_\_ Explain \_\_\_\_\_

Currently prescribed medications \_\_\_\_\_

Medication needs to be given at school

## ADHD

Currently prescribed medications \_\_\_\_\_

Medication needs to be given at school

## OTHER HEALTH CONCERNS

Cancer  Heart Condition (be specific) \_\_\_\_\_

Hemophilia  Sickle Cell Anemia

Other \_\_\_\_\_

Other \_\_\_\_\_

## MEDICAL PROVIDER INFORMATION

	Name	Phone
Pediatrician/Primary Care Provider		
Dentist		
Eye Doctor		
Other Specialist		
Preferred Hospital		

**Please note: A Medication Authorization Form must be completed for every medication that needs to be given at school.**

I, \_\_\_\_\_, hereby authorize my child's health care provider and designated provider of health care in the school setting, to include all school-sponsored activities (e.g. athletic programs, field trips, etc.), to discuss my child's health concerns and/or exchange information pertaining to this form. Any photocopy of this form carries the same authority as the original.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date