Welcome to Extended Care!

2018-2019

Monday-Friday

6:30 am-6:00 pm

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. Both Early Care and After School Care are available. Listed below, you will find Extended Care (EC) options and fees for the current school year.

REGISTRATION FEE **$25.00 per Student / $50.00 Maximum per Family**			
Early Care **6:30 am - 8:00 am**		**After School Care** **3:00 pm - 6:00 pm**	
3 Day	**5 Day**	**3 Day**	**5 Day**
$625	$965	$1,240	$1,930
Drop-in Daily Rate - $6		***Drop-in Daily Rate - $13***	
BUNDLE PACKAGES		**3 Day**	**5 Day**
Early Care + After School Care		$1,640	$2,480
SAVINGS		$225	$415

We offer an annual, per semester, or 10-month payment plan.

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._____ **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.

8._____ 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.

9._____ 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. Debbie Drivas, EC 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*