



EXTENDED CARE PROGRAM SY2020-2021

(One Application per student is required)

October 2020

To be considered for acceptance in our Extended Care Program, the following items must be completed and submitted to our school office by **Friday, October 16, 2020**.

Extended Care Program Packet (which includes):

- Registration Form
- Emergency Medical Authorization Form
- Emergency Contacts
- Designated Pick-Up Form
- Financial Contract
- Terms and Conditions
- Handbook Verification Form

There are only 60 spaces available. Acceptance will be on a first-come-first-serve basis.
INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED. PLEASE COMPLETE ALL FIELDS.

If you have any questions concerning our Extended Care Program application packet, please feel free to contact our school office at #677-4475. We look forward to meeting and working with you and your child(ren).

Sincerely,

A handwritten signature in black ink that reads "Ms. B. Sandobal". The signature is written in a cursive, flowing style.

Ms. Beverly Sandobal, Principal

ST. JOSEPH PARISH SCHOOL
PROVIDING QUALITY CATHOLIC EDUCATION

94-651 FARRINGTON HIGHWAY WAIPAHO, HI 96797

TEL (808) 677-4475

WEB: WWW.STJOSEPHWAIPAHO.ORG

FAX: (808) 677-8937

EMAIL: SJPS@STJOSEPHWAIPAHO.ORG



REGISTRATION FORM
SY2020-2021

Child's Name _____

Address _____ Home Phone _____

Birth Date _____ Age _____ Grade _____ Teacher _____

Parent(s) or Legal Guardian(s) with whom child lives:

Parent/Legal Guardian's Name _____

Occupation _____ Phone/Cell _____

Business Address _____

Parent/Legal Guardian's Name _____

Occupation _____ Phone/Cell _____

Business Address _____

Parent/Legal Guardian Signature _____ Date _____

Parent/Legal Guardian Signature _____ Date _____



EMERGENCY MEDICAL AUTHORIZATION FORM SY2020-2021

Child's Name (Last, First) _____

Grade _____

In the event of illness or injury to my child, which in the judgment of the St. Joseph Parish School staff requires emergency treatment, my permission is granted to call the following doctors in the order named, after attempts made to contact me or those listed under emergency contacts by telephone have been unsuccessful:

Doctor _____ Phone _____

Address _____

The hospital emergency room of my choice is: _____

My child is allergic to the following:

Medications _____

Foods _____

Other _____

I hereby release St. Joseph Parish School from any claim arising out of the doctor's actions. All medical expenses shall be the responsibility of the parent(s) or legal guardian(s).

Parent/Legal Guardian Signature

Printed

Date

Parent/Legal Guardian Signature

Printed

Date

Father/Legal Guardian business/cell phone: # _____

Mother/Legal Guardian business/cell phone: # _____



EMERGENCY CONTACTS

SY2020-2021

In cases where my/our child(ren) are ill, injured, or in the event of an emergency closure of the school and I/we cannot be contacted, the school authorities have my/our permission to contact and release my/our child(ren) to the custody of one of the following people. (NOTE: These individuals may be required to present a valid picture ID).

Name: _____ Relationship: _____

Home phone: _____ Cell/business phone: _____

Name: _____ Relationship: _____

Home phone: _____ Cell/business phone: _____

Name: _____ Relationship: _____

Home phone: _____ Cell/business phone: _____

Please note any special information that is important for us to know:

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DESIGNATED PICK-UP FORM
SY2020-2021

1. Name: _____ Relationship to student: _____

Address: _____

Home phone: # _____ Business phone: # _____ Cell: # _____

2. Name: _____ Relationship to student: _____

Address: _____

Home phone: # _____ Business phone: # _____ Cell: # _____

3. Name: _____ Relationship to student: _____

Address: _____

Home phone: # _____ Business phone: # _____ Cell: # _____

4. Name: _____ Relationship to student: _____

Address: _____

Home phone: # _____ Business phone: # _____ Cell: # _____

NOTE: Only the individuals designated on this form will be allowed to pick up your child(ren). A picture I.D. may be requested.



FINANCIAL CONTRACT SY2020-2021

Family Name: _____

Name of Child(ren):

_____ Homeroom _____
_____ Homeroom _____
_____ Homeroom _____

Please select payment plan of choice: (cost is per child)

BEFORE SCHOOL CARE ONLY (5:45 am –6:45 am)		
_____ ANNUAL	\$350.00	First Payment Due: Nov. 10, 2020
_____ MONTHLY (Full Time)	\$45.00	Date Due: 10 th of each month
_____ DAILY (Part-Time)	\$6.00 per day	Date Due: 10 th of each month

AFTER SCHOOL CARE ONLY (up until 5:30 pm)		
_____ ANNUAL	\$800.00	First Payment Due: Nov. 10, 2020
_____ MONTHLY (Full Time)	\$120.00	Date Due: 10 th of each month
_____ DAILY (Part-Time)	\$15.00 per day	Date Due: 10 th of each month

BEFORE AND AFTER SCHOOL CARE – Full time		
_____ ANNUAL	\$1200.00	First Payment Due: Nov. 10, 2020
_____ MONTHLY	\$165.00	Date Due: 10 th of each month

LATE PICK UP FEE begins at 5:31pm. Late pick up fees are due upon pick-up. (1-30 min.- \$20.00) (31-60 min.- \$60.00)

PAYMENTS WILL BE DEDUCTED FROM YOUR FACTS ACCOUNT

Parent/Legal Guardian Signature _____ Date _____

Parent/Legal Guardian Signature _____ Date _____



TERMS AND CONDITIONS SY2020-2021

PLEASE INITIAL EACH ITEM LISTED TO VERIFY THAT YOU HAVE READ EACH ITEM.

- _____ The Extended Care Program is licensed to accommodate no more than 60 students per day.
- _____ Parents are to notify in writing or by phone if child(ren) will not be attending the Extended Care Program for an extended amount of time.
- _____ After School Care services **ARE NOT PROVIDED on early dismissal days.** A late fee will be charged for students who are not picked up promptly and is due upon pick up.
- _____ No credit is given for days when the child does not utilize the Extended Care Program.
- _____ Monthly payments are due by the 10th of each month for 7 months starting in November and ending in May. A late fee of \$25 per occurrence will be assessed on the 11th day of the month. The account must be paid in full by the last day of school **May 28, 2021.**
- _____ Daily fees will be billed the following month (i.e. September for August) and are due the 10th of that month. The account must be paid in full by the last day of school **May 28, 2021.**
- _____ Checks returned by the bank for insufficient funds will require future payments to be made in cash or money order. A fee will be charged for insufficient funds.
- _____ If tuition and /or any daily, late or overtime fees are not paid timely, parents may be required to remove their child(ren) from the program. A 30-day written notice is required if child(ren) withdraws from the program to allow space for other students.
- _____ The fee per child for Extended Care Services provided is charged regardless of the number of days the child attends.

Parent/Legal Guardian Signature

Date

Parent/Legal Guardian Signature

Date



Student & Parent Handbook Verification Form
(Extended Care Program section)
SY2020-2021

Please sign and return by **October 16, 2020** (*one application per child*)

I/We, _____, have read the St. Joseph Parish
Parent/Legal Guardian Names (Printed)

School Student and Parent Handbook (Extended Care Program section) and agree to be governed by
said stated policies.

Family Name (please print)

Child's name

Grade

Child's name

Grade

Child's name

Grade

Parent's/Legal Guardian's Signature

Date

Parent's/Legal Guardian's Signature

Date

FOR OFFICE USE ONLY:

Date submitted: _____

Payment received: _____