



EXTENDED CARE PROGRAM SY2023-2024

(One Application per student is required)

August 2023

To be considered for acceptance in our Extended Care Program, the following items must be completed and submitted to our school office by **Friday, August 4, 2023.**

Services will begin on Monday, August 7th.

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

Due to State of Hawaii licensing, 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,

Ms. B. Sandobal

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
SY2023-2024

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 SY2023-2024

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

SY2023-2024

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
SY2023-2024

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 SY2023-2024

Family Name: _____

Name of Child(ren):

| | |
|-------|----------------|
| _____ | Homeroom _____ |
| _____ | Homeroom _____ |
| _____ | Homeroom _____ |
| _____ | Homeroom _____ |

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

| | | |
|---|----------------|--|
| BEFORE SCHOOL CARE ONLY (5:45 am –7:00 am) | | |
| _____ ANNUAL | \$400.00 | First Payment Due: Aug. 15, 2023 |
| _____ 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 | \$1150.00 | First Payment Due: Aug. 15, 2023 |
| _____ MONTHLY (Full Time) | \$125.00 | Date Due: 10 th of each month |
| _____ DAILY (Part-Time) | \$16.00 per day | Date Due: 10 th of each month |

| | | |
|---|-----------|--|
| BEFORE AND AFTER SCHOOL CARE – Full time | | |
| _____ ANNUAL | \$1500.00 | First Payment Due: Aug. 15, 2023 |
| _____ 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 SY2023-2024

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 15th of each month for 9 months starting in September 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 24, 2024.**
- _____ Daily fees will be billed the following month (i.e. September for August) and are due the 15th of that month. The account must be paid in full by the last day of school **May 24, 2024.**
- _____ 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)
SY2023-2024**

Please sign and return by August 4, 2023 (*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: _____