

TOWN OF SMITHTOWN

SUPERVISOR

EDWARD R. WEHRHEIM

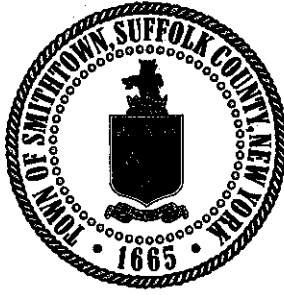
Town Council

Thomas J. McCarthy

Lynne C. Nowick

Lisa M. Inzerillo

Thomas W. Lohmann



School Age Child Care

Maureen Fiorello

Director

Dear Parent/Guardian,

The School Age Child Care program will be offered on the two Parent/Teacher Conference half days on Tuesday, December 3, 2019 and Wednesday, March 11, 2020. These half days will be offered to all families in the Smithtown School District.

The program will be offered on Tuesday, December 3, 2019 beginning upon dismissal and operating until 6:00 pm or 6:30 pm. The fee for this additional day is \$42.00 per child with a 6:00 pm pick-up or \$46.00 per child with a 6:30 pm pick-up. **This fee is non-refundable.**

Please complete the following forms and return them with your check or money order to the School Age Child Care office at 7 New York Ave., Smithtown, NY 11787. Please write "**½ Day**" on the envelope. **Deadline to register is Thursday, November 14, 2019.**

- **Half Day Registration Form** – Complete form.
- **Half Day Enrollment Form** – Be sure to fill out all contact names and phone numbers and sign your name in the two places at the bottom of the form.
- **Medical Forms** – Must be downloaded from www.smithtownny.gov - under Town Departments, then School Age Child Care, then 2019/2020 SACC Medical Forms. They must be completed by a medical professional. Unfortunately, School District medical forms cannot be accepted. Should a child have a prescription for an epi-pen or inhaler, a non-expired device must be provided to the SACC staff and additional forms must be completed.

A bag lunch with your child's name clearly printed on the outside is required. **Please do not send in peanut butter or nuts of any kind.** Drinks and an afternoon snack will be provided.

Should you have any questions, please do not hesitate to contact my office at 631-360-7517.

Sincerely,



Maureen Fiorello

MF:kc

"Approval for distribution of these materials is not an endorsement of such services, activities and/or products by the Smithtown Central School District."

7 NEW YORK AVENUE, SMITHTOWN, NEW YORK 11787
Tel: (631) 360-7517 Fax: (631) 360-7604 Email: schoolagechildcare@smithtownny.gov
www.smithtownny.gov

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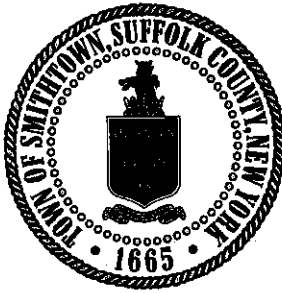
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HALF DAY REGISTRATION FORM

Name of School: _____

Name of Child/Children: _____

I am registering my child/children for:

Tuesday, December 3, 2019 till 6:00 pm: _____

Tuesday, December 3, 2019 till 6:30 pm: _____

I have enclosed a check or money order for \$42.00 per child for a 6:00 pm pick-up or \$46.00 per child for a 6:30 pm pick-up. **This fee is non-refundable.**

Please include a current email address that you would like a confirmation sent to. Please do not consider your child/children registered unless **you receive a confirmation email from this office.**

I agree to send my child with a bag lunch with the child/children's name clearly printed on the bag. **Please do not send peanut butter or nuts of any kind.**

Parent/Guardian Signature

Date

Current Email Address for Confirmation

HALF DAY ENROLLMENT FORM – SCHOOL AGE CHILD CARE PROGRAM 2019-2020

Please complete ALL information. Type or print neatly using block letters. Office Use Only –Initial & Date: _____

Today's Date: _____ Name of School: _____

Child's Name (First and Last)	Age	Gender	Date of Birth	Grade as of Sept. 2018	Epi-Pen/Inhaler
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____

Tuesday December 3, 2019 till 6pm: _____

Tuesday December 3, 2019 till 6:30pm: _____

Home Phone: _____ Child Lives With: _____

Address: _____ Town: _____ Zip Code: _____

Parent #1 Name: _____ Cell Phone: _____

Name of Employer: _____ Work Phone: _____ Hours: _____

Primary Email Address: _____

Parent # 2 Name: _____ Cell Phone: _____

Name of Employer: _____ Work Phone: _____ Hours: _____

SIGN OUT PROCEDURE: Child must be signed out by an authorized person (18 yrs. or older) for PM program. Any changes in this list must be in **writing** & submitted to the School Age Child Care Office; **48-hour notice required;** **At least TWO people other than parents are required & must be local.**

1. Name: _____ Phone: _____ Cell: _____ Relationship: _____

2. Name: _____ Phone: _____ Cell: _____ Relationship: _____

3. Name: _____ Phone: _____ Cell: _____ Relationship: _____

4. Name: _____ Phone: _____ Cell: _____ Relationship: _____

EMERGENCY MEDICAL INFORMATION: List two local people to be notified in case of emergency or illness when parents and/or guardian are not available. List telephone numbers where these people may be reached during program hours.

Name: _____ Phone: _____ Cell: _____ Relationship: _____

Name: _____ Phone: _____ Cell: _____ Relationship: _____

Doctor's Name: _____ Office Phone: _____

Dentist's Name: _____ Office Phone: _____

I have provided information on my child's special needs (Allergies, Diet, Disabilities and/or Medical Information) to SACC, as may be necessary to assist SACC in properly caring for my child in case of emergency.

Emergency Medical Release: If emergency medical or dental care is deemed necessary and I cannot be reached, I authorize the SACC staff to act on my behalf in granting permission for my child to receive emergency treatment.

Parent/Guardian Signature: _____

PHOTOGRAPHIC PERMISSION: (check one) I DO I DO NOT give permission to have my child appear in any media coverage approved by the SACC staff. Parent / Guardian Signature: _____