Caledonia Area Community Education
2025 Summer SAC Program Registration

Child Name:_____ Date:_____

Enrollment is not guaranteed until the following:

- Enrollment forms are filled out completely per child
- $20 registration fee is paid per child if not enrolled during school year
- $35/daily rate per child
- You receive confirmation from Mrs. Von Arx (SAC Supervisor)
- Questions Contact: meghan_vonarx@cps.k12.mn.us

Summer SAC Schedule

Summer SAC starts Wednesday, May 28th and ends on Friday, August 8th.
If the schedule is going to vary please email weekly schedule to meghan_vonarx@cps.k12.mn.us

May/June					July					August				
x	x	28	29	30		1	2	3	x					1
2	3	4	5	6	7	8	9	10	11	4	5	6	7	8
9	10	11	12	13	14	15	16	17	18					
16	17	18	x	20	21	22	23	24	25					
23 ____ 30	24	25	26	27	28	29	30	31						

Approximate Drop Off Time:_____ Approximate Pick Up Time:_____

Summer Activity Schedule

1. Activity Name/Location _____

   Start and End Times _____Dates _____

2. Activity Name/Location _____

   Start and End Times _____Dates _____

3. Activity Name _____

   Start and End Times _____Dates _____

Child Care Enrollment Form

CHILD INFORMATION

Child's Name:_____ Date of Birth:_____ Gender: Female Male
(First, Middle, Last)

PARENT INFORMATION

Parent 1 Name:_____ Relationship to Child: _____

Email Address:_____ Cell Phone Number:_____

Place of Employment:_____ Work Phone Number:_____

Home Address:_____

Does the child reside at this location? Yes No

Parent 2 Name:_____ Relationship to Child: _____

Email Address:_____ Cell Phone Number:_____

Place of Employment:_____ Work Phone Number:_____

Home Address:_____

Does the child reside at this location? Yes No

EMERGENCY CONTACTS: The persons to be notified in an emergency when parents can not be reached, who are authorized to pick up the child or accept the child if dropped off

Name:_____ Relationship to Child:_____

Home Address:_____ Cell Number:_____

Place of Employment:_____ Work Number:_____ Email:_____

Name:_____ Relationship to Child:_____

Home Address:_____ Cell Number:_____

Place of Employment:_____ Work Number:_____ Email:_____

AUTHORIZED PERSONS: Persons, other than parents and emergency contacts, who are authorized to pick up the child or accept the child if dropped off

Name:_____ Relationship to Child:_____

Home Address:_____ Cell Number:_____

Place of Employment:_____ Work Number:_____ Email:_____

Name:_____ Relationship to Child:_____

Home Address:_____ Cell Number:_____

Place of Employment:_____ Work Number:_____ Email:_____

HEALTH INFORMATION

Physician Name:_____ Phone Number:_____

Medical Facility Name and Address:_____

Dentist Name:_____ Phone Number:_____

Dental Facility and Address:_____

Medication:

My child takes medication on either a scheduled or as-needed basis: Yes No

If yes, please fill out below:

Medication:_____ Dose:_____

Frequency:_____ Time it needs to be given:_____

Allergies:

My child has an allergy we are aware of: Yes No

If yes please fill out below:

Allergy:_____What to avoid:_____

Response system if needed:_____

_____

Special Medical Condition:

My child has another special medical condition (asthma, special dietary requirement, etc.): Yes No

If yes please fill out below:

Special Health Need:_____

Triggers that may cause problems:_____

Signs or symptoms to watch for (be specific):_____

Steps the child care provider should follow:_____

When to call parents:_____

When emergency care is needed:_____

Non Prescription Products:

I authorize CAPS Care/SAC staff to apply the following products to my child:

____ Lotion Sunscreen (non-aerosol) ____ Bug Spray(non-aerosol) ____ Baby Wipes ____ Hand Lotion

____ Diaper Cream ____ Lip Balm

Parent Signature:_____ Date:_____

PERMISSION, ACKNOWLEDGMENTS, and RELEASE OF INFORMATION

Please initial each of the following statements:

____I give the center permission to take my child on supervised walks off the center premises.

____ I understand that the center may discontinue care of my child if he/she does not adjust to the program.

____I hereby give consent for the exchanges of information between employees of CAPS Care/SAC and Caledonia Area Public School District whenever such exchange would better enable either party to meet the needs of my child. Personal information is not released to persons outside of CAPS Care/SAC aside from the Department of Human Services Licensing Division and the public school district in which you reside, unless we have your written approval or except as required under applicable law or pursuant to court order, subpoena, or other legal requirement.

____ I give permission to allow my child's photo to be taken for public use, such as Facebook, a newspaper article, or brochures, regarding CAPS Care or SAC.

____ The Caledonia Area Public School District does not provide any type of health or accident insurance for illness or injuries incurred by your child while attending CAPS Care/SAC. By signing below, I acknowledge that we have adequate insurance to protect our son(s)/daughter(s) in case of an accident.

____ In consideration of my child being permitted to participate in CAPS Care/SAC, I agree to release, hold harmless and indemnify CAPS Care/SAC, its employees, and all other organizations, of whatever connection and all claims, demands, costs, losses, and expenses which I, my heirs, and personal representatives may have arising out of his/her participation in CAPS Care/SAC or through the use of any and all facility connected herewith. I understand that every possible precaution will be exercised to assure the safety and welfare of my child. I also understand that CAPS Care/SAC and its authorized representatives shall not be responsible, financially or otherwise, should an accident occur.

____I hereby give permission for my child to receive emergency treatment (First Aid and CPR) by any of the qualified staff members at CAPS Care/SAC. I also give permission for the staff to act in the case of an emergency, or when a parent cannot be reached or is delayed. I give permission for my child to be transported by ambulance, aid care or staff vehicle to an emergency center for treatment. In an event that I cannot be contacted, I further consent to the medical, surgical, and hospital care treatment and procedure to be performed for the child by a licensed physician or hospital when deemed immediately necessary to safeguard my child's health. In case of an emergency, I agree to pay all costs of transportation and medical costs.

____ I recognize my responsibility to respect the rules of CAPS Care/SAC. I also recognize my responsibility to help my child respect the rules in order to better provide a positive experience for all program participants. I agree to be responsible for knowing the contents of the parent handbook, to pay the agreed upon tuition contract, and to share responsibility for damages my child may cause while participating in CAPS Care/SAC.

Parent Printed Name:_____

Parent Signature:_____**Date:**_____