

**Caledonia Area Community Education  
2025-2026 SAC Program Registration**

Child Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Enrollment is not guaranteed until the following:**

- Enrollment forms are filled out completely per child
  - \$35 registration fee is paid per child
- You receive confirmation from Meghan Von Arx (SAC Supervisor)

Program	Ages	Hours	Tuition
School Age Care (SAC)	PreK-5th grade	Monday-Friday 6:00am-Start of School End of School-6:00pm  Non-School Days: 6:00am-6:00pm	AM: \$12/day PM: \$15/day AM & PM: \$20/day  Non-School Days: \$40/day  Summer: \$40/day

## 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:** \_\_\_\_\_