

**BEXLEY RECREATION & PARKS DEPARTMENT
2016/17 Before & After School Program - Registration Form**

Please register for one of the following schools and also AM, PM, or both AM & PM coverage by checking the appropriate box:

<input type="checkbox"/> Cassingham Elementary	<input type="checkbox"/> Maryland Elementary	<input type="checkbox"/> Montrose Elementary
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Please print clearly in all sections.

Child's Name _____ DOB ___/___/___ Age _____ Sex _____ Grade (2016-17) _____

Parent Name _____ Address _____

Email _____ Phone: Home _____ Work _____ Cell _____

Other parent (if different than above)

Parent Name _____ Address _____

Email _____ Phone: Home _____ Work _____ Cell _____

REGISTRATION / PAYMENT POLICY

Payment must be made prior to the start of the program. For participant convenience, monthly payments have been split into bi-monthly payments. For those that have credit cards on file, payments will be charged to the card on the 1st and 15th of the month. In the event that the 1st or 15th falls on the weekend or on a holiday, the payment/charge will be due the closest business day prior to the scheduled payment day (i.e. the 15th falls on a Saturday, payment will be due on Friday, the 14th).

CANCELLATION POLICY

There will be **NO** cancellation fee for cancellation of days/month made 2 weeks prior to the first day of school on Wednesday, August 17th. Cancellations of any months made after 2 weeks prior to the first day of school will include a \$25 cancellation fee for each month of cancellation. Cancellation of any individual days after the start of school on Wednesday, August 17th will result in a \$5 cancellation fee for each day cancelled. Failure to give notification at least two weeks prior to the changed week will result in having to pay the full fee.

T-Shirt Size: (**Youth**) Small Medium Large (**Adult**) Small Medium Large XLarge

Monthly Registration

AM Care (\$145)

PM Care (\$205)

Both AM & PM (\$340)

Payment Dates

August	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	August 15 th
September	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	September 1 st & 15 th
October	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	October 1 st & 15 th
November	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	November 1 st & 15 th
December	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	December 1 st & 15 th
January	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	January 1 st & 15 th
February	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	February 1 st & 15 th
March	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	March 1 st & 15 th
April	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	April 1 st & 15 th
May	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	May 1 st

Individual Day Registration

Monday

Tuesday

Wednesday

Thursday

Friday

AM Only - \$10 Per Day	<input type="checkbox"/>				
PM Only - \$15 Per Day	<input type="checkbox"/>				
AM & PM - \$25 Per Day	<input type="checkbox"/>				

Please check this box if your individual days will not be consistent (i.e. a Monday one week and a Friday another week). If that is the case, also contact Mindy Walsh, Before/After Care Administrator at campadmin@Bexley.org to schedule your registration days.

If the child registered on this form is a 2016 Jeffrey Summer Camp Program (JSCP) participant, by checking this box, you give us permission to use the 2016 JSCP forms (Permission/Photo Release, Dismissal, and Medical Forms) as the official Before & After School Program Forms. The only other form you would need to fill out is the payment form.

RELEASE / PERMISSION

I, as parent or legal guardian representing this minor, agree to release the City of Bexley, its officers, employees and volunteers from any and all liability for accidents, injuries, loss of and / or damage to my / our person or property that may arise out of my child's participation in or at the listed activity / activities. I / we are aware that participating in activities or use of facilities involves certain risk of injury despite safety precautions. I give permission for my child to take part in all camp activities, including trips away from camp. In the event of an accident or emergency, if my child's physician is not available, I grant permission to call another licensed physician. I authorize the camp staff to act for me according to their best judgment.

I have read the Before & After Care Program policies and payment terms and accept full responsibility for 100% payment of all program fees.

Signature of Parent, Custodian, or Guardian

Date

Ohio Department of Job and Family Services
**CHILD ENROLLMENT AND HEALTH INFORMATION
 FOR CHILD CARE CENTERS AND TYPE A HOMES**

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name		Date of Birth		First Day at Center	
Home Address				City	
State	Zip Code		Home Telephone Number		
Parent/Guardian Name			Relationship to Child		
Home Address			Home Telephone Number		
City			State	Zip	
Email Address (if applicable)			Cell Phone		
Parent's Work/School Telephone Number			Parent's Work/School Name		
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which number(s) above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email					
Where can you be reached while your child is in this program?					
Parent/Guardian Name			Relationship to Child		
Home Address			Home Telephone Number		
City			State	Zip	
Email Address (if applicable)			Cell Phone		
Parent's Work/School Telephone Number			Parent's Work/School Name		
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which number(s) above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email					
Where can you be reached while your child is in this program?					
Emergency Contacts: Parents cannot be listed as emergency contacts. List the name of <u>at least one person</u> who can be contacted in the event of an emergency or illness if you cannot be reached . Any person listed should be able to assist in contacting you. At least one person listed must be within one hour of the center/home, able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.					
Name		Name			
City	State	City		State	
Telephone Number	Relationship to Child		Telephone Number	Relationship to Child	
Other numbers where emergency contact can be reached (if applicable)			Other numbers where emergency contact can be reached (if applicable)		
Name of Physician or Clinic/Hospital					
Street Address					
City		State	Telephone Number		

Child's Name

Allergies, Special Health or Medical Conditions, and Food Supplements

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or type A home.

Does your child have any food, medication or environmental allergies? *(check all that apply)*

- No
 Yes - check all that apply Food Medication Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor child for symptoms, take action if a reaction occurs, or give emergency medication to your child? *(check one)*

- No
 Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Does your child have a special health or medical condition? *(check one)*

- No
 Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? *(check one)*

- No
 Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? *(check one)*

- No
 Yes - please explain

If yes, does this medication, food supplement, or medical food need to be administered at the child care center/type A home?

- No
 Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.
 N/A - program does not administer any medications.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? *(check one)*

- No
 Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

- No
 Yes - written instructions from the child's health care provider must be on the JFS 01217 "Request for Administration of Medication."
 N/A - child does not attend a full time program.

Child's Name
List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff or medical personnel in an emergency situation.
List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page.

Diapering Statement

Is your child toilet trained? <input type="checkbox"/> Yes (If yes, skip to Emergency Transportation Authorization section) <input type="checkbox"/> No (If no, fill out the following)	
The program's policy is to check diapers every _____ hours. Please indicate if you want your child's diaper checked according to the center/type A home's policy or another:	
<input type="checkbox"/> I agree with the program's schedule	<input type="checkbox"/> I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

<u>Give <i>Permission</i> to Transport</u>	OR	<u>Do Not Give <i>Permission</i> to Transport</u>
Center or Type A Home Name	Do not sign both	Center or Type A Home Name
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.		does not have permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:
Parent's Signature Date		Parent's Signature Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the center's or type A home's policies and procedures/handbook. <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(check one)</i>	
This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care. After the child is attending the program the administrator shall have the parent/guardian review and initial the form when any changes/updates are made and at least annually. The parent/guardian and the administrator or designee shall initial and date the form in the section below to indicate when the form was last reviewed.	
Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.			
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note: This is a prescribed form which must be used by centers and type A homes to meet the requirements of rules 5101:2-12-37 and 5101:2-13-37. This form must be on file at the center or type A home on or before the child's first day of attendance and thereafter while the child is enrolled.

Ohio Department of Job and Family Services
CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name (<i>print or type</i>)		Date of Birth
<input type="checkbox"/> This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care.		
Signature of Examining Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner		Date of Examination
Name of Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner		Telephone Number
Street Address		
City, State and Zip Code		

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS

Diseases for Immunization	PHYSICIAN /PHYSICIAN'S ASSISTANT/ADVANCED PRACTICE NURSE/CERTIFIED NURSE PRACTITIONER COMPLETES <i>check all that apply for each disease</i>		
	Immunized	In Process of Immunization	Medically Contraindicated/ Not Age Appropriate
Chicken pox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Haemophilus influenzae type b	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza <input type="checkbox"/> Seasonal Vaccine Not Available	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pertussis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumococcal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poliomyelitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rotavirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rubella	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Initial beside the disease(s) being declined above and sign below.

Signature of Parent	Date of Signature
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Recommended Assessments/Screenings			
Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lead	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemoglobin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	
Measurements:		Notes:	
Height)		
Weight)		
BMI			

Ohio Department of Job and Family Services
REQUEST FOR ADMINISTRATION OF MEDICATION
Child Care Centers and Type A Homes

This form is valid for no longer than twelve (12) months. One form must be used for each medication.

Box 1 - The following section must **always** be completed by the parent/guardian.

<u>Check all that apply:</u>	
<input type="checkbox"/> Prescription medication	<input checked="" type="checkbox"/> Topical product or lotion
<input type="checkbox"/> Nonprescription medication	<input type="checkbox"/> Food supplement
<input type="checkbox"/> Refrigeration required	<input type="checkbox"/> Modified diet
<u>Complete all of the following information:</u>	
Name of child: _____ Date of birth: _____ Weight _____	
Name of medication: <u>Hand Sanitizer</u> Exact dosage: <u>1 Pump</u>	
To be administered at the following times: <u>Before Eating</u>	
For the following period of time: <u>While Attending Camp</u>	
Parent/Guardian signature: _____ Date: _____	

Box 2 -The following section must be completed by a **licensed physician, a licensed dentist or an advance practice nurse** when:

1. A physician's instruction is needed for a nonprescription medication (e.g. child is underage or underweight per the label instructions); or
2. It is a sample medication without a prescription label; or
3. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period or is a topical product or lotion that is being used for a skin ailment and is to be given no longer than fourteen consecutive days; or
4. The child is on a modified diet (an entire food group is eliminated); or
5. The medication contains codeine or aspirin.

_____ is under my care and should receive _____ <small>(name of child) (name of medication, vitamin, diet)</small>		
as follows: _____ <small>(include dosage and instructions)</small>		
Possible side effects to watch for are: _____		
Expiration date: _____ (may not exceed 12 months from the date of this request for medications or food supplements)		
_____ Signature of physician, dentist or advance practice nurse	_____ Date of signature	_____ Phone number

This form must be used by child care centers and type A homes to meet the requirement of rules 5101:2-12-31 and 51-1:2-13-31.



Bexley Recreation & Parks

Jeffrey Summer Camp Program Dismissal Form



****ONLY ONE FORM NEEDED PER FAMILY****

Playcamp (4 & 5 Year Old) 3-Day Half 3-Day Full (M-W-F) 5-Day Half 5-Day Full (M-F)	Camp Jeffrey Woods (Entering 1 st – Entering 3 rd Grade)	Camp Jeffrey Park (Entering 4 th – Entering 7 th Grade)	Camp Adventure (Entering 7 th – Entering 9 th Grade)
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The following persons have my permission to pick up my child(ren) from Jeffrey Summer Camp.
I understand that my child(ren) will not be released without a picture ID.

Reminder: Campers, at no time, are allowed to sign themselves out of camp.

Child's Name: _____ Camp: _____

Name of Authorized Person(s)

Relationship to Child

1. _____ Parent/Guardian

2. _____ Parent/Guardian

3. _____

4. _____

5. _____

6. _____

7. _____

Parent Name: _____

Parent Signature: _____ Date: _____

Comments:



Bexley Recreation & Parks

Jeffrey Sumer Camp Program Permission/Photo Release Form



****ONLY ONE FORM NEEDED PER FAMILY****

Playcamp (4 & 5 Year Old) 3-Day Half 3-Day Full (M-W-F) 5-Day Half 5-Day Full (M-F)	Camp Jeffrey Woods (Entering 1 st – Entering 3 rd Grade)	Camp Jeffrey Park (Entering 4 th – Entering 7 th Grade)	Camp Adventure (Entering 7 th – Entering 9 th Grade)
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Parent's Name _____ Best Available # _____ # _____

Secondary Contact _____ Best Available # _____ # _____

Liability Release

I hereby grant my child permission to accompany his/her group on the above field trip(s), and do also hereby release the Bexley Recreation Department, drivers, and supervisors (staff or other) of all responsibility for any injuries which might occur traveling to and from their destination, or at their destination. I, as participant or legal guardian representing a minor participant, agree to release the City of Bexley, its officers, employees and volunteers from any and all liability for accidents, injuries, loss of and/or damage to my/our person or property that may arise out of my/our participation in our presence at the listed activity/activities. I/we are aware that there are certain risks of possible dangers in participation in this activity. I have entered into this agreement of my own free will.

Transportation by the Bexley City Schools and/or other Certified Transportation Company

**The field trips will be scheduled between camp registration and the parent meeting.
A handout will be passed out at the parent meeting listing the field trips for the current summer.
This permission slip covers all scheduled trips for the Jeffrey Summer Camp Program 2016.**

Photographic Release

I, the undersigned participant (age 18 or older) or parent/guardian of a participant (under the age of 18), hereby give permission without restrictions to the Bexley Recreation Department and its designees or licensees to photograph, film, video or take sound recordings of me or my child, as the case may be, in connection with such participation in Bexley Recreation Department programs.

I grant the Bexley Recreation Department permission of use the negatives, prints, motion pictures, videos, digital images, and/or sound recordings, or any reproduction thereof, for promotional, informational and instructional purposes in any manner determined to be appropriate by the Bexley Recreation Department.

I waive any right to compensation or monetary damages with respect to such use by the Bexley Recreation Department of my, or my child's, name, likeness, picture and/or voice, including without limitation any claim for invasion of privacy.

I have read and understand the terms of this Photographic Release, and I am signing this release as my free and voluntary act, irrevocably binding myself, my child (if applicable) and my heirs and personal representatives.

Child's Name: _____ Camp: _____

Parent/Guardian's Name _____

(Please Print)

Parent/Guardian's

Signature _____ Date _____

Ohio Department of Job and Family Services
REQUEST FOR ADMINISTRATION OF MEDICATION
Child Care Centers and Type A Homes

This form is valid for no longer than twelve (12) months. One form must be used for each medication.

Box 1 - The following section must **always** be completed by the parent/guardian.

<u>Check all that apply:</u>	
<input type="checkbox"/> Prescription medication	<input type="checkbox"/> Topical product or lotion
<input type="checkbox"/> Nonprescription medication	<input type="checkbox"/> Food supplement
<input type="checkbox"/> Refrigeration required	<input type="checkbox"/> Modified diet
<u>Complete all of the following information:</u>	
Name of child: _____ Date of birth: _____ Weight _____	
Name of medication: _____ Exact dosage: _____	
To be administered at the following times: _____	
For the following period of time: _____	
Parent/Guardian signature: _____ Date: _____	

Box 2 -The following section must be completed by a **licensed physician, a licensed dentist or an advance practice nurse** when:

1. A physician's instruction is needed for a nonprescription medication (e.g. child is underage or underweight per the label instructions); or
2. It is a sample medication without a prescription label; or
3. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period or is a topical product or lotion that is being used for a skin ailment and is to be given no longer than fourteen consecutive days; or
4. The child is on a modified diet (an entire food group is eliminated); or
5. The medication contains codeine or aspirin.

_____ is under my care and should receive _____ (name of child) (name of medication, vitamin, diet)		
as follows: _____ (include dosage and instructions)		
Possible side effects to watch for are: _____		
Expiration date: _____ (may not exceed 12 months from the date of this request for medications or food supplements)		
_____ Signature of physician, dentist or advance practice nurse	_____ Date of signature	_____ Phone number

This form must be used by child care centers and type A homes to meet the requirement of rules 5101:2-12-31 and 51-1:2-13-31.

Ohio Department of Job and Family Services
**CHILD CARE PLAN FOR HEALTH CONDITIONS OR MEDICAL PROCEDURES
 FOR CHILD CARE CENTERS AND TYPE A HOMES**

If care is provided for a child who has an ongoing health condition that requires child specific care or may require a medical procedure, the parent/guardian shall complete this form. The center staff shall implement the plan. This requirement does not include short term illnesses, unless the child care staff member needs to perform a medical procedure for the child. A separate plan must be written for each condition that requires different actions to be taken.

Child's Name	Date of Birth
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Describe the health condition.

Describe the medical procedure to be completed and expected benefits of treatment, or N/A, no medical procedure required.

List activities/foods/environmental conditions to avoid or N/A, nothing to avoid.

Symptoms to watch for and actions to be taken if the symptoms are observed.

Is any medication required? Yes No
 (If yes, complete JFS 01217 "Request for Administration of Medication", in addition to this form.)

In an emergency does this child require additional assistance (more than other children of the same age or in the same group) to evacuate? Yes No If yes, please describe:

In the event that the child care program must be evacuated, are there medications or supplies that must be taken with this child? Yes No If yes, please describe:

Signature of Trainer (Trainer must be a parent/guardian or certified professional)	Date
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Signature of child care staff members who have been informed about the child's condition so they can care for the child according to this care plan or trained to perform the medical procedure.
There must always be a trained staff member present when the child is present.

Signature	Date	I have been <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

I give my permission for the staff listed above to perform the procedures in my child's care plan as described above.

Parent's Signature	Date
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Administrator's Signature	Date
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This form may be used for children with health conditions as defined in Rules 5101: 2-12-38 and 5101: 2-13-38.

**BEXLEY RECREATION & PARKS DEPARTMENT
2016/17 Before & After School Program
Deposit & Direct Withdraw Form**

Name of Child/Children:

1. _____

<input type="checkbox"/> Cassingham Elementary	<input type="checkbox"/> Maryland Elementary	<input type="checkbox"/> Montrose Elementary
--	--	--

2. _____

<input type="checkbox"/> Cassingham Elementary	<input type="checkbox"/> Maryland Elementary	<input type="checkbox"/> Montrose Elementary
--	--	--

3. _____

<input type="checkbox"/> Cassingham Elementary	<input type="checkbox"/> Maryland Elementary	<input type="checkbox"/> Montrose Elementary
--	--	--

4. _____

<input type="checkbox"/> Cassingham Elementary	<input type="checkbox"/> Maryland Elementary	<input type="checkbox"/> Montrose Elementary
--	--	--

Name on Card: _____ **Credit Card Type:** VISA MC

Account # _____ - _____ - _____ **Exp. Date:** ____ / ____ **3-Digit Code:** _____

*****Please check Daily/ Monthly for direct withdrawal.**

******Payment for all individual days will be charged to the cards on the 1st and 15th of the month of attendance.**

DAILY/ Monthly (Please check for direct withdrawal)

By signing this form, you are giving permission to the Bexley Recreation & Parks Department to charge to the above listed credit card and/or account number the amount owed each day/bi-monthly for Before & After Care Program. All late fees, cancellation charges, and outstanding payments will be assessed to this card. Payment for any other Bexley Recreation sponsored program may NOT be charged as a result of this form.

Signature: _____ **Date:** _____

REGISTRATION / PAYMENT POLICY

Payment must be made prior to the start of the program. For participant convenience, monthly payments have been split into bi-monthly payments. For those that have credit cards on file, payments will be charged to the card on the 1st and 15th of the month. In the event that the 1st or 15th falls on the weekend or on a holiday, the payment/charge will be due the closest business day prior to the scheduled payment day (i.e. the 15th falls on a Saturday, payment will be due on Friday, the 14th).

CANCELLATION POLICY

There will be **NO** cancellation fee for cancellation of days/month made 2 weeks prior to the first day of school on Wednesday, August 17th. Cancellations of any months made after 2 weeks prior to the first day of school will include a \$25 cancellation fee for each month of cancellation. Cancellation of any individual days after the start of school on Wednesday, August 17th will result in a \$5 cancellation fee for each day cancelled. Failure to give notification at least two weeks prior to the changed week will result in having to pay the full fee.