Western Indiana Community Action Agency, Inc.

SCHOOL AGE CHILD CARE
CONFIDENTIAL ENROLLMENT APPLICATION
2016-2017

There is a $15.00 registration fee, per child.

For office use only
Scholarship _____ Registration Fee _____ Emergency Rate _____

Name of Child:_____Age_____Sex_____Grade_____

Address:_____City_____Zip_____

Phone:_____ Birth date_____ School_____

Child resides with (Please circle one): Both Parents Mother Father Other
Comments_____

Father/Guardian's Name_____ Daytime Phone_____

Place of Work_____ Alternate Phone_____

Mother/Guardian's Name_____ Daytime Phone_____

Place of Work_____ Alternate Phone_____

Parent email address:_____

Do you give consent for your child to be photographed or videotaped for the purpose of advertisements or grants? _____

Additional people we may contact or that may pick up your child in an emergency:

Name_____ Daytime Phone_____ Relationship_____

Name_____ Daytime Phone_____ Relationship_____

Name of Hospital you prefer for emergency treatment. _____

Does your child have any medical conditions, allergies, routine medications or other concerns we should know about to better care for your child?

_____

Food allergies must have a doctor's statement before we can serve your child an alternate snack.

Do you give consent for VCSC to share information with SACC Program office? All information will be kept confidential between the two agencies. _____

Do you give consent for your child to watch rated PG Movies? _____

Do you approve of Basic CPR or First Aid treatment for your child when necessary? _____

Does your child receive services from Covered Bridge Special Education District? _____
If yes, what is the diagnosis? _____

2016 - 2017 Rate Schedule

Weekly Rates

Number of Hours	One Child	Each Additional Child
Up to 3.5 Hours	**29**	**27**
3.75 to 6.25 Hours	**39**	**35**
6.5 to 13.25 Hours	**58**	**52**
13.5 to 25 Hours	**73**	**65**

Late Fee of $1.00 **per child, each minute** to be added after 6:00 PM.
No Exceptions!

In case of illness or injury of my child, and in the event that all efforts to reach me fail, I hereby give my permission to SACC to follow the appropriate procedure to secure the medical attention needed for my child. I will assume responsibility for the necessary expenses involved in the treatment of my child. I also grant permission to release my child to the people listed above in the event they cannot contact me. I understand that in the event my child is not picked up by 6:00 pm, and all attempts to contact parents/emergency contacts have failed, SACC will contact the appropriate authorities.

By signing below, I acknowledge that I am responsible for payment of all childcare expenses and that the cost of childcare has been explained to me. I will pay off my School Age Child Care balance on a weekly basis, either by paying the childcare providers at my child's school, mailing a check to the SACC office, bringing a payment into the office at 705 S. 5th St. or making a payment through PayPal at www.wicaa.org. If I become delinquent in my payments, I understand that I may receive a letter in the mail explaining that my childcare privileges have been terminated until I pay my balance in full. For future child care services I further understand that I will have to pay in advance.

Signature of Parent/Guardian: _____ Date: _____

I have received a parent handbook.

Signature of Parent/Guardian: _____ Date: _____

Upon completion of application, please submit by:
-Mail @
705 South 5th Street
Terre Haute, IN 47807
or
-Hand to the School Age Child Care
provider at your elementary school.
Phone: 812-232-1264 Fax: 812-232-9634