LAKEWOOD
CATHOLIC
ACADEMY

2018-19 After Care Program

Lakewood Catholic Academy is pleased to provide a quality program that meets the needs of parents who require before and/or after school supervision for their children in grades kindergarten through eight. Personal discipline, social development, emotional well being and academic growth are emphasized through the following activities:

- Homework assistance
- Daily opportunities for reading
- Opportunities to participate in small group games, which provide basic skills such as sharing, taking turns, and respecting others
- Group or individual play in the gym or on the school's beautiful grounds
- Opportunities for daily imaginative play
- Opportunities to develop self-discipline through adherence to regular routines and responsibilities

The hours of operation for the program are from 3:00 to 6:00 p.m. after school, every day that school is in session. Full-day care is available on select days when school is not in session, based on the amount of children that need care for those days. The program also operates during summer vacation for full-day sessions.

Please contact Program Director Sara Koumandarakis with any questions at 216.521.0559, extension 3044 or by email at skoumandarakis@lcasaints.com.

After Care Fees

Parents interested in enrolling their child(ren) in the program should complete the form below and return it, along with a non-refundable $60 deposit per child, to the Main Office.

Care Program daily fees are as follows:

After Care: $15.00 per day
All Day Care (full day)* $50.00 per day

*(offered on selected days during the school year when school is not in session – availability based on demand)

Child(ren)'s Name(s) Grade in Fall 2018

_____ _____

_____ _____

_____ _____

Parent Name (1)_____ (2)_____

Address_____

City_____ State_____ Zip_____

Parent (1) Phone_____ Parent (2) Phone_____

Parent (1) Email Address: _____

Parent (2) Email Address: _____

My child will require after school care for the 2018-19 school year during the following days of the week:

____Monday ____Tuesday ____Wednesday ____Thursday ____Friday

____ Days of the Week will vary

LCA AFTER CARE

CHILD PICK UP AUTHORIZATION FORM

2018-19

Child's Name: _____ Grade: _____

Home Phone #_____ Birthday ____ /____ / _____

I give permission for my child to be released from LCA Before and Aftercare Program to the people listed below at any time. I understand that LCA Before and Aftercare Program staff will require any person listed below to show photo identification before it will release my child.

Name _____
Phone number _____
Relationship _____

Name _____
Phone number _____
Relationship _____

Name _____
Phone number _____
Relationship _____

Name _____
Phone number _____
Relationship _____

Name _____
Phone number _____
Relationship _____

Name _____
Phone number _____
Relationship _____

PARENT/ GUARDIAN Agreement

1. I must notify LCA Before and Aftercare Program immediately of any changes on this form.
2. If the person picking up my child appears to be under the influence of drugs or alcohol, or in any other way presents a risk to my child's safety, the staff may refuse to release my child. If I, or another person listed on the above form, cannot be contacted, the Lakewood Police Department will be called.

MY SIGNATURE ACKNOWLEDGES MY UNDERSTANDING OF AND AGREEMENT TO THE ABOVE

_____ _____

Parent/Guardian **Date**

LAKEWOOD CATHOLIC ACADEMY
EMERGENCY MEDICAL AUTHORIZATION

2018-2019
School year

Child's Name:_____

Address: _____

Phone: _____

Purpose -- To enable parents to authorize emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached.

Part I or Part II must be completed.

PART I (TO GRANT REQUEST)

In the event reasonable attempts to contact me at _____ (phone) or _____ (other parent) at _____ (phone) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. _____ (preferred physician), or Dr. _____ (preferred dentist) or in event the designated preferred practitioner is not available, by another licensed physician or dentist;

and (2) the transfer of the child to _____ (preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:_____
_____
_____

_____ _____ _____
Date Signature of Parent Address

**DO NOT COMPLETE PART II IF YOU COMPLETED PART I **
PART II (REFUSAL TO CONSENT)

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to: _____
_____

_____ _____ _____
Date Signature of Parent Address

Dear Before/After Care Program Parents:

We make every effort to send out invoices for Before/Aftercare services as soon as each month ends. Please indicate below your method of payment:

_____ will pay with check, by 15th of month following service

_____ will pay by ACH (Direct Debit) on the 15th of month following service

Attached is the authorization form for ACH payment of Before/Aftercare services. Direct debits are processed on the 15th of the month after the month of services are incurred. (Example: September services will be debited on the October 15th).

If you signed up for ACH previously, check the box on the form accordingly. *(You do not need to complete another authorization form unless your bank information has changed).*

To sign up for ACH, please complete the attached form and send it to the LCA Business Office. If you do not sign up for ACH, your check will be due on the 15th. Thank you!

_____	_____	_____
Student's Name	Parent's Signature	Date

Below is authorization to pay fee for Before & After Care for the following student(s) (please list students names):

_____

_____

_____

_____

_____

Lakewood Catholic Academy
Authorization Agreement for
Automatic Payments

I hereby authorize Lakewood Catholic Academy to directly debit my checking account for payment of fees for Before & After Care Program to the account listed below. I hereby authorize Lakewood Catholic Academy to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my account listed below.

☐ Check box if authorizing to use same bank account information as previous year.

Instructions:

-Payments will be debited to your account on the 15th of every month.
If the 15th falls on a weekend or holiday your account will be debited on the following business day.
-Monthly debited amount is for the prior month's fee plus any outstanding balance.
Transit/ABA number is the nine digit number, generally preceding your account number.
-Please attach voided check with this paperwork.

Financial Institution Name and Branch Location	Transit/ABA No. (Nine digit Number)	Account No.	Type of Account
Institution: _____			Checking ☐
Branch: _____			Savings ☐

Automatic debit authority is to remain in full force until Lakewood Catholic Academy has received written notification from me of its termination in such timely manner as to afford Lakewood Catholic Academy and Financial Institution a reasonable opportunity to act on it.

_____ _____
Signature Date

_____
Please Print Name