ST AGATHA CHILD CARE
SUMMER PROGRAM 2022

Dear Parents,

We are so excited to be planning for our summer fun on these cold, snowy January days. We are all ready for a return to a more traditional summer camp experience this year. Our plans are to offer a variety of activities to include swimming, field trips, tennis instruction, sports clinics, bike riding, art instruction and some academic enrichment during the summer camp weeks. Complete the attached registration form, indicate the weeks you wish your child to attend and return it with your deposit as soon as possible. All forms must be complete and include the deposit for your registration to be valid. Registrations will be open to the public on Tuesday, February 8th.

- Age Group — Entering Grades 1-6
- Dates — Monday, June 13 thru Friday, July 29
- Times — 8:00 am – 5:00 pm
- Lunch — Bring a packed lunch, drink and water bottle daily.
  - Pizza offered on Fridays (optional to order)
  - Childcare will provide a daily afternoon snack.
- Tuition — 5 days - $225/wk, 4 days - $185.00/wk, M,W,F - $150/wk, T,Th- $100/wk. Tuition **includes** a summer camp T-shirt.
- Swimming — Visit Tremont Swimming Pool three days a week
- Weekly Field Trips — Weekly Field Trips to various central Ohio sites, i.e.: Columbus Zoo, Sawmill Lanes, Chiller Ice Rink, Metro Parks.
- Weekly Library Visits — Upper Arlington Main Library

The first week's payment/deposit due at the time of registration. The balance of tuition is due in 2 equal payments on Monday, June 13th and Monday, July 11th.

Teachers will plan and facilitate arts and crafts, science, daily math/ reading times, indoor and outdoor recreational activities and special projects reflecting the children's interests. We will reveal a special summer theme before the camp begins.

ST. AGATHA CHILD CARE
SUMMER 2022
REGISTRATION FORM

Child's Name________________________________ DOB___________ Girl ____ Boy___

Age__________ School attending in fall______________ Grade level in fall________________

Address____Zip__________________________

Email address____

Mother's Cell___________________________Father's Cell_____________________________

Known Allergies____EpiPen yes___ no___

T-Shirt Size: (Please Circle One) Child - sm med large x-large
Adult - sm med large x-large

SCHEDULE:

My child will be attending the summer program for _________weeks. <u>(Please circle the weeks your child will be attending.)</u>

June 13 June 20 June 27 July 5 July 11 July 18

July 25

My child will attend: (Please circle one)		
	5 days – Mon thru Fri	$225.00 per week
	4 days – Mon thru Thurs	$185.00 per week
	3 days – Mon Wed Fri	$150.00 per week
	2 days – Tues Thurs	$100.00 per week

<u>CONTRACT:</u>

I understand that I am contracting for ______________ weeks of St. Agatha Childcare Summer Session. I further understand that a non-refundable payment of one week's tuition (according to the number of days attending) is required at the time of registration. The full amount of the deposit will be credited to your summer tuition. Payment for half of the remaining balance is due by **<u>Monday, June 13</u>** and the remaining balance is due by **<u>Monday, July 11.</u>** **<u>Make your choices carefully since you may not drop days or weeks after registration. This contract is considered final.</u>**

Signature of Parent ________________________________Date____________

Emergency Medical Authorization Form
St. Agatha School
Diocese of Columbus, Ohio

Student's Name______________________________ Teacher/ Grade_______________
Address____ Zip__________________________
Phone ___________________ Birth date ____________ Male___ Female___

Father/Guardian's Name____
Address_______________________________ Zip____________________________________
Home Phone______________ Work Phone______________ Cell Phone/ Pager______________
Email____
Place of Employment____

Mother/ Guardian's Name____
Address____ Zip ___________________________
Home Phone______________ Work Phone______________ Cell Phone/ Pager______________
Email____
Place of Employment ____

In the event this student becomes ill at school but does not need medical attention, name three people, i.e., relative, neighbor, child care provider, to be contacted if you cannot be reached.

1.____________________________ Relationship______________ Phone_________________

2.____________________________ Relationship_______________ Phone_________________

3. ____________________________ Relationship _______________ Phone_________________

Give any pertinent information regarding the health of this child:

Medical/ Health Needs: ____
____

Allergies/ Treatment:____
____

Dietary Needs / Restrictions:____
____

Medications: ____
____

EMERGENCY MEDICAL AUTHORIZATION

Name______________

(State of Ohio Revised code Section 3313.712)

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

**********PART I OR PART II MUST BE COMPLETED**********

PART I: TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called.

Physician_________________________________ Phone______________________________
Dentist __________________________________ Phone ________________________________
Medical Specialist _________________________ Phone ______________________________
Local Hospital ____________________________ Emergency Room Phone _______________

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to 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 prior to the performance of such surgery.

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

____
____
____

Date_____________________ Signature of Parent/ Guardian______________________________

**********DO NOT COMPLETE PART II IF YOU COMPLETED PART I*********

PART II: REFUSAL TO CONSENT

I do **NOT** give 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 the following action:

____
____

Date _____________________ Signature of Parent/ Guardian____________________________