SCHOOL-AGE AFTERCARE 2025-2026 REGISTRATION FORM

Date Received: _____

by:_____

Student Name:	
□ Male □ Female	**Date of Birth:**
Elementary School:	
Address:_____**City**_____	
Stare:_____**Zip Code**_____	
Phone Number:	
Email:	

PARENT/FAMILY OCCUPATIONS & PLACE OF BUSINESS:

Guardian #1_____ Guardian #2_____
Relationship: _____ Relationship: _____
ADDRESS: _____ ADDRESS: _____
City _____ State _____Zip_____City _____ State ___Zip_____
WORK: (_) _____CELL: (___) _____WORK: (_) _____CELL: (___) ___
Mom's Occupation _____Dad's Occupation _____
EMAIL: _____ EMAIL: _____
HOME PHONE: (_) _____HOME PHONE: (__) _____

ADDITIONAL PARENTAL INFORMATION (IF REQUIRED)

Guardian: _____ Guardian: _____
ADDRESS: _____ ADDRESS: _____
City _____ State _____Zip_____ City _____ State _____Zip_____
WORK: (___) _____CELL: (____) _____ WORK: (___) _____CELL: (____) _____
EMAIL: _____ EMAIL: _____

EMERGENCY CONTACT INFORMATION:

Emergency Contact Name: _____Relationship: _____Phone: (___) _____
Emergency Contact Name: _____Relationship: _____Phone: (___) _____
Emergency Contact Name: _____Relationship: _____Phone: (___) _____

AUTHORIZATION FOR PICK-UP (ID REQUIRED) – MUST SHOW A VALID PICTURE ID

1. NAME: _____RELATIONSHIP: _____PHONE# (___) _____
2. NAME: _____RELATIONSHIP: _____PHONE# (___) _____
3. NAME: _____RELATIONSHIP: _____PHONE# (___) _____

SHARE INFORMATION WITH: _____

STUDENT HEALTH INFORMATION

Please list health problems: _____ Please list physical limitations: _____

Please list allergies (including food): _____ Please list regular medications; limitations: _____

Family Physician: _____ Phone: (___) _____

Family Dentist: _____ Phone: (___) _____

Health Insurance: _____ Phone: (___) _____

ADDITIONAL INFORMATION

1. **SCHOOL -AGE AFTER CARE hours are 2:30 pm to 5:30 pm, Monday to Friday on days** when LCPS is in session. Tuition for School -Age After Care without pick up is $545.00 plus tax. Tuition for School -Age After Care with pick up from Loma Heights Elementary, Highland Elementary, and Sonoma Elementary is $594.00 plus tax. Late fees will be charged if the child is picked up after 5:40 pm—the rate of $5.00 for every 5 minutes. Please call 523-1616 if an emergency arises, causing you to be late.

   Parent Signature: _____ Date: _____

2. State subsidies are also accepted. You would contact ECECD at the Early Childhood and Care Department to start the application process. The Early Childhood and Care Department can be reached at 1(800)832-1321 for further assistance

   Parent signature: _____ Date: _____

3. To better assist the needs of each child please answer the following: **School District:** _____
   Elementary School your child will attend for 2025-2026: _____
   Current IEP: ☐ **Yes** ☐ **No**

   Parent signature: _____ Date: _____

4. Tuition is based on a **SCHOOL-YEAR ENROLLMENT** (10 months) but will be paid in monthly installments. There are two payment options: an auto-debit either through a checking account or credit card. (Please see the office to set-up.) Automatic debits using your preferred method will be run on the 1st of the month. Returned auto-debits will incur an additional $25 fee.

   Parent signature: _____ Date: _____

5. All students will be required to give a **30-day written notice** to the front office for withdrawal from the program.

   Parent signature: _____ Date: _____

6. The following people CANNOT or DO NOT have permission to pick up from after school program:

   NOT AUTHORIZED _____
   NOT AUTHORIZED _____

   Parent(s) Signature _____ Date: _____

Acknowledge receipt of attendance calendar and sign-up for Class Dojo _____

Office Use Only

Date of Entry: _____	**Date of withdrawal:** _____
Payment Option Form offered _____	**Withdrawal form signed** _____
All final paperwork completed _____	**Account Balance closed** _____
Office Employee taking sign up form _____	**Office Employee taking withdraw form** _____

GYM MAGIC, INC.
ASSUMPTION OF RISK, WAIVER OF LIABILITY, MEDICAL AUTHORIZATION

As the legal guardian of (children associated with waiver), or as an adult participant, I recognize that potentially severe injuries, including permanent paralysis or death can occur in sports or activities involving height or motion, including but not limited to all of Gym Magic Inc. programs. In addition, swimming or any activity in or around water can result in brain damage or drowning. I am also aware that participation in day camps/preschool involves transportation to and from various field trips and as a result my child could be injured or killed in a vehicular accident. Being fully aware of these dangers, I voluntarily consent to the aforementioned person participating in any and all Gym Magic Inc. programs, camps and activities and **I ACCEPT ALL RISKS** associated with that participation.

I further acknowledge, understand, appreciate and agree that my participation may result in possible exposure to and illness from infectious diseases, including, but not limited to, MRSA, Influenza, and COVID-19. While particular rules and personal discipline may reduce this risk, the risk of serious illness and death does exist. I knowingly and freely assume all such risks, both known and unknown, even if arising from the negligence of the releases or others, and assume full responsibility for my participation and exposure.

In consideration for allowing my child or myself to use these facilities, I, on my own behalf and the behalf of my child and our respective heirs, administrators, executors and successors, hereby **COVENANT NOT TO SUE** and **FOREVER RELEASE Gym Magic, Inc.,** its officers, directors, shareholders, employees or agents from all liability for any and all damages or injuries suffered by my child or myself while under the instruction, supervision, or control of Gym Magic Inc., without limitation, those damages or injuries resulting from acts of negligence on the part of its officers, directors, shareholders, employees or agents.

In the event of an accident or emergency I would like my above-mentioned child or myself to be taken to a hospital for medical treatment and I hold Gym Magic Inc., and its representatives harmless in their execution of this action. Additionally, I hereby agree to individually provide for 100 % of future medical expenses, which may be incurred by my child or myself as a result of any injury sustained while participating at or for Gym Magic Inc.

I have read and understand this ASSUMPTION OF RISK and WAIVER OF LIABILITY and MEDICAL AUTHORIZATION and I VOLUNTARILY affix my name in agreement. I further understand the risk of exposure to injury and/or infectious diseases, for myself and my child, as a participant, spectator at events, classes or our presence at the facility.

By my attendance in any activities and/or events, I am granting my permission for my child and myself to be filmed, audio taped, or photographed by any means and are granting full use of our likeness, voice, and words without compensation.

Parent, Legal Guardian's Signature _____Date _____

Child and Adult Care Food Program
LETTER TO HOUSEHOLDS

Name of Facility / Center / Site /	EPICS #	Phone Number
Gym Magic Foundation- The Village	1532420	575-523-1616

Instructions: This letter must accompany the Income Eligibility Application. Dear

Clear

Parent / Guardian or CACFP Participant:

Gym Magic Foundation- The Village Participates in the Child and Adult Care Food Program (CACFP) administered by the United States
Name of Sponsor/Facility / Center /

Department of Agriculture. Please help us comply with the requirements of the CACFP by completing, signing, and returning the attached statement as soon as possible. This information is necessary to decide the level of CACFP reimbursement your center is eligible to receive for the meals served to children and/or adult participants in our program. This form will be treated as confidential information. All participants in our program receive their meals free of charge, but the eligibility category determination affects the federal funding we receive. Foster Children: A foster child enrolled in our program, which is the legal responsibility of a welfare agency or court, may be certified as eligible for free meals regardless of the household income. Please refer to the instructions on how to complete the Income Eligibility Application form.

SNAP - Supplemental Nutrition Assistance Program (formerly the Food Stamp Program): If your household is currently receiving benefits under the Supplemental Nutrition Assistance Program (SNAP) or Food Distribution Program on Indian Reservations (FDPIR) and your child is enrolled in a childcare center you need only to list the case number sign and date the form.

If your household is receiving benefits under the Supplemental Nutrition Assistance Program (SNAP), Supplemental Security Income (SSI), Medicaid, or Food Distribution Program on Indian Reservations (FDPIR) and an adult in your home is enrolled in an Adult Daycare Center; then you need only to list their case number sign and date the form. Otherwise, an adult household member must complete the form and disclose the total current household income by source and the names of all household members. The person completing the form must sign, provide a social security number, and date when completed.

The income you report must be last month's total gross household income listed by source for each household member. If last month's income does not accurately reflect your circumstances, you may provide your annual income or use last year's income if no significant changes have occurred. If your household's income is equal to or less than the amounts indicated for your household's size on the chart below, your provider may qualify for maximum reimbursement rates. The Department of Agriculture defines a household as a group of related or unrelated individuals (not residents of a boarding house or an institution) who are living as one economic unit (i.e., sharing living expenses).

INCOME ELIGIBILITY GUIDELINES
(Effective From July,1,2024 To July,1,2025)

	FREE				REDUCED			
HOUSEHOLD SIZE	YEAR	MONTH	EVERY 2 WEEKS	WEEK	YEAR	MONTH	EVERY 2 WEEKS	WEEK
1	19,578	1,632	753	377	27,861	2,322	1,072	536
2	26,572	2,215	1,022	511	37,814	3,152	1,455	728
3	33,566	2,798	1,291	646	47,767	3,981	1,838	919
4	40,560	3,380	1,560	780	57,720	4,810	2,220	1,110
5	47,554	3,963	1,829	915	67,673	5,640	2,603	1,302
6	54,548	4,546	2,098	1,049	77,626	6,469	2,986	1,493
7	61,542	5,129	2,367	1,184	87,579	7,299	3,369	1,685
8	68,536	5,712	2,636	1,318	97,532	8,128	3,752	1,876
FOR EACH ADDITIONAL FAMILY MEMBER	+6,994	+583	+269	+135	+9,953	+830	+383	+192

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing, or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form (AD-3027) found online at How to File a Complaint and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; fax: (202) 690-7442; or email: program.intake@usda.gov. This institution is an equal opportunity provider.

Bianet Bustamante
Name of Sponsor / Center Representative

Bianet Bustamante
Signature of Sponsor / Center Representative

1/24/25
Date

Child and Adult Care Food Program
INSTRUCTIONS FOR COMPLETING THE INCOME ELIGIBILITY FORM

Name of Sponsor / Center / Site	EPICS #	Phone Number
Gym Magic Foundation- The Village	1532420	575-523-1616

PARTICIPANT INFORMATION:

List all enrolled participants you are applying for who are in care. List

each enrolled participant's date of birth.

If you are applying for a foster child, list only one foster child on each form. A foster child may be eligible for free meals regardless of household income.

Child Care Centers: If the participant enrolled is in a Child Care Center and receives benefits through Supplemental Nutrition Assistance (SNAP) (*formerly food stamps or Food Distribution Program on Indian Reservation (FDPIR)*, please indicate the appropriate case number in the spaces provided and sign the form. Do not use the number on your card. You do not need to complete household and income information.

Adult Day Care Centers: If the participant enrolled is in an Adult Daycare Center and receives benefits thru Supplemental Nutrition Assistance (SNAP) formerly, food stamps, Food Distribution Program on Indian Reservation (FDPIR), Supplemental Security Income (SSI) or Medicaid, please indicate the appropriate case number in the spaces provided and sign the form. Do not use the number on your card. You do not need to complete household and income information.

If you do not receive benefits and have no case number for participants enrolled at the center, you must complete all parts of the IEA (Household and Income information).

HOUSEHOLD AND INCOME INFORMATION
Not required to be completed if case# is provided above.

List all household members. A household is a group of related or unrelated individuals who are living as one economic unit (i.e., sharing living expenses).

Provide the most current income by source for all household members. This can be based on the most recent information the month prior to completing

the application. Reported income needs to be reported on the same. The income reported on the application must include all income before taxes and

before other deductions.

A foster child is defined as a ward of the court or welfare agency. Only the foster child's "personal use" income is listed.

Personal use income includes:

- Funds that are specified by the welfare agency as being for the personal use of the child. (If no funds are specified, the funds received from the welfare agency are not to be

  considered as income. Record "0" on personal income.)
- Money received from any source. This includes, but is not limited to, funds received from trust accounts, from the child's family, and earnings from the child's employment other

  than occasional or part-time jobs.

SIGNATURE _____ Date_____

The adult family member completing the application must sign and date the application.

If the enrolled participant is not a recipient of benefits and has not provided a case number, the adult family member signing the application must provide a social security number.

If you do not have a social security number, check the "box" provided. Otherwise, failure to provide the social security number (if you have one) will make the Income Eligibility Application invalid and will reduce the level of CACFP reimbursement your family's Child Care Center receives for meals served to the children and/or adult participants enrolled for care in their center.

Child and Adult Care Food Program
INCOME ELIGIBILITY APPLICATION

New Mexico Early Childhood Education & Care Department

Sponsor /Facility	EPICS ID:
Gym Magic Foundation- The Village	1532420

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing, or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html at any USDA office, or write a letter addressed to USDA and provide the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by 1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C.
20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

Child Care Centers: To apply for **FREE** meals - If you are receiving benefits under the Supplemental Nutrition Assistance Program (SNAP) or Food Distribution Program on Indian Reservations (FDPIR) fill in your child's name, date of birth, age, the SNAP Case number or FDPIR case number and sign the form. DO NOT complete other Household Members or income information.

****Adult Day Care:** To apply for **FREE** meals - If the enrolled participant household is the recipient of the Supplemental Nutrition Assistance Program (SNAP) or receives Supplemental Security Income (SSI) or Medicaid (MED), complete name, DOB, age, SNAP, SSI, and/or Medicaid case number and sign the form. DO NOT complete other Household Members or income information.

Enrolled Participant(s) Information (attach additional pages if necessary)				**Benefit Information** *(If applicable, check the type of benefit & provide the required case number)*	
First and Last Name	If foster Child Check here	Date of Birth:	Age	****Child Care Centers Only**-check a box* ☐ SNAP ☐ FDPIR	****Adult Care Centers Only**- check a box* ☐SNAP ☐FDPIR ☐SSI ☐MED
	☐			*Case Number:	**Case Number:
	☐				
	☐				
	☐				

Foster Child (complete if a foster child is enrolling for care)

☐ Check this box if this application includes a foster child. List the amount of the child's "personal use" monthly income.

All Other Household Members List the first and last names of each person living in your household, related or not (such as grandparents, relatives, or friends who live with you). You must include yourself and all children living with you. Attach another sheet of paper if you need to

First and Last Name	***First and Last Name***

Total Number in Households: _____

Household Income (Please indicate the source and amount of current income for all members of your household. Please follow the definition of income specified in the standards for determining free and reduced-price eligibility in your parent letter. If you receive more than one check from any of these sources, please indicate the total monthly amount received.)

Wages, Salary: $	Child Support (Alimony): $	Social Security: $
Pension or Retirement: $	Unemployment: $	Other Income: $

If necessary, convert multiple income schedules to annual income (Multiply weekly income by 52, biweekly by 26, monthly by 12)

Total Income: $_____ ☐**Weekly** ☐**Monthly** ☐ **Annually** *(Check one)*

PENALTIES FOR MISREPRESENTATION: I certify that all the above information is true, the food stamp or FDPIR number is correct, or all income is reported. I understand that this information is being given for the receipt of Federal funds, that institution officials may verify the information on the statement, and that the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

_____
Signature of Adult Family Member

Last Four Digits of Social Security Number*

☐ Check if no SS# _____
Date

Privacy Act Statement:

This explains how we will use the information you give us. The Richard B. Russell National School Lunch Act requires that, unless the participant's food stamp or FDPIR number is provided, you must include the social security number of the household member signing the statement or an indication that the household member signing the statement does not possess a social security number. Provision of a social security number is not mandatory, but if a social security number is not provided or an indication is not made that the adult household member signing the statement does not have one, the statement cannot be approved. The social security number may be used to identify the household member in carrying out efforts to verify the correctness of the information on the statement. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a food stamp or FDPIR office to determine current certification for receipt of SNAP (food stamp) or FDPIR benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to verify the amount of income received. These efforts may result in a loss or reduction of or reduction of benefits, administrative claims, or legal action if incorrect information is reported.

For Sponsor Use Only				
☐ Child Day Care Center	☐ Adult Day Care Center	☐ Approved Free	☐ Approved Reduced	☐ Paid

Name of Sponsor	Name of Person Approving Form	Approving date	Date Disenrolled
Gym Magic Foundation- The Village	Bianet Bustamante		