

**SCHOOL-AGE AFTERCARE - 2024-2025 REGISTRATION FORM**



Student Name: \_\_\_\_\_  
Sex: F \_\_\_ M \_\_\_ Birthday \_\_\_ / \_\_\_ / \_\_\_ Age: \_\_\_\_\_  
Elementary School: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_  
Mom (First): \_\_\_\_\_ Mom (Last): \_\_\_\_\_  
Dad (First): \_\_\_\_\_ Dad (Last): \_\_\_\_\_

**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 \$399 plus tax. Tuition for School -Age After Care with pick up from Loma Heights Elementary, Highland Elementary, and Sonoma Elementary is \$450 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 2022-2023:** \_\_\_\_\_  
**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 1<sup>st</sup> 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 ClassTag** \_\_\_\_\_

## Office Use Only

<b>Date of Entry:</b> _____ <b>Payment Option Form offered</b> _____ <b>All final paperwork completed</b> _____ <b>Office Employee taking sign up form</b> _____	<b>Date of withdrawal:</b> _____ <b>Withdrawal form signed</b> _____ <b>Account Balance closed</b> _____ <b>Office Employee taking withdraw form</b> _____
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**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 / Gym Magic/Ashley's Garden or The Village
EPICS # 1532420
Phone Number 575-523-1616

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

Clear

Parent / Guardian or CACFP Participant:

Name of Sponsor/Facility / Center / Participates in the Child and Adult Care Food Program (CACFP) administered by the United States

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,1,2023 To July,1,2024)

Table with 9 columns: Household Size, Year, Month, Every 2 Weeks, Week, Year, Month, Every 2 Weeks, Week. Rows for household sizes 1-8 and an additional member row.

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.

Bianet Bustamante

Signature of Sponsor / Center Representative

7/14/23

Date



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



Name of Sponsor / Center / Site <b>Gym Magic/Ashley's Garden or The Village</b>	EPICS # <b>1532420</b>	Phone Number <b>575-523-1616</b>
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**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 **7/14/23**

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



Sponsor /Facility

Gym Magic/Ashley's Garden or The Village

EPICS ID:

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.

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)
\*Child Care Centers Only-check a box
\*\*Adult Care Centers Only- check a box

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

Table with columns: 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
Date
Check if no SS#

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.

For Sponsor Use Only
Child Day Care Center Adult Day Care Center Approved Fee Approved Reduced Paid
Name of Sponsor Name of Person Approving Form Approving date Date Disenrolled