

West Bridgewater Public Schools Surround Care Program



Dear Parents/ Guardians:

The Surround Care Program is located in the Spring Street School for kindergarteners and in the Rose L. MacDonald School for grades 1-6. Also, the Howard School has a morning program that starts at 7 a.m.

The program begins at 7:00 a.m. and ends at 6:00 p.m. You will be billed each week for the time your child actually attends the program. The billing rate is \$5.00/hour. Please refer to our Parents' Manual for information regarding our program. To register your child, please complete the following pages and return it to the school office as soon as possible. Registration must be completed and received **before your child can start the program.**

Ms. Sarah Amaral, Business Manager

Please check the days and times your child will probably attend so that we can plan for sufficient staffing.

My child _____ in grade ___ will attend:

Morning: Monday ___ Tuesday ___ Wed. ___ Thursday ___ Friday ___

Afternoon: Mon. ___ Tues. ___ Weds. ___ Thurs. ___ Friday ___

Parents' Names: Father _____ Mother _____

Address: _____

Father's work phone #: _____ cell: _____

Mother's work phone#: _____ cell: _____

Home phone: _____ email: _____

Parent signature: _____ Date: _____

Emergency Information

Please give the names of two people who may be notified in case of an emergency or illness if the parents cannot be reached.

Name: _____ Relationship: _____

Home phone: _____ Work: _____ cell: _____

Name: _____ Relationship: _____

Home phone: _____ Work: _____ cell: _____

Please list who is authorized by you to pick up your child.

Name: _____ phone: _____

Name: _____ Phone: _____

Photograph/Videotape Permission

I give permission for my child to be photographed or videotaped for any newspaper, radio or television publicly related to the program.

Parent Signature _____ Date _____

Health

Please indicate below if your child has any dietary or medical conditions.

Food allergies: _____

Allergies: _____

Bee stings? _____ To medication: _____

Special Health issues: _____

To Whom it may Concern:

In my absence, this will serve to authorize any medical personnel to furnish any emergency care to my minor son/daughter, _____, in any case where his/her condition, medical or surgical, is or appears to be, of an emergency nature. You are hereby authorized to furnish any such care and treatment and to administer any anesthetics to my son/daughter deemed necessary or advisable.

Yes, I give permission. Signed _____ Date: _____

Parent or Guardian

No, I do not give permission. Signed _____ Date: _____

Parent or Guardian