2018-2019 School Year
SACC REGISTRATION FORM
LEWISBURG AREA SCHOOL DISTRICT

Student's Name: ____

(Last) (First) (Middle)

Address: ____ Birthdate____________ Grade ____

(Street) (City) (State) (Zip)

Home Phone #: ___________________________ Cell Phone # _______________________

Gender: ________ Student Resides with: Both Parents ______ Father _____ Mother _____ Other______ (specify below)

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Father's Name: ____ Occupation:____________________________

Place of Employment: ____ Phone #: ______________________________

Mother's Name: ____ Occupation: ___________________________

Place of Employment: ____ Phone #: ______________________________

Emergency Contact Person: ____ Phone #: ______________________________

Relation of Emergency Contact (to student): ____

Email address: ____

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School Attending: _______ Kelly ______ Linntown

Morning care only: $7.00 per day
Afternoon care only: $10.00 per day
Both before and after care: $16 per day
Two-Hour Delays: $10.00
Early Dismissal: $12.00
Full day care (Some Holidays & Snow Days) $24 per day

By signing this form, you are agreeing to use of our SACC program for the 2018-2019 School Year, at the rates listed above.

PARENT SIGNATURE: ____ **Date:** _________________

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For Office Use Only

Date of Enrollment in SACC Program ___________________________________

Signature of Person Completing the Form: ____ Date: ____________________

Please identify all persons with permission to pick up child/children. Anyone coming to pick up the child other than the people listed on this form will not be permitted to leave with the student unless arrangements have been made in advance of the pick up date. They will be responsible for providing the staff with photo identification.

Name: Relationship: Phone #:

____
____
____
____
____

Please list any thing you would like us to know about your child for example; allergies, special accommodations, concerns, dietary needs, or any other relevant information below.

____
____
____
____
____

Please Return all Paperwork To:

SACC at Kelly Elementary

Or

Leah Shaffer
Lewisburg Area School District
1951 Washington Avenue
Lewisburg, PA 17837
570-522-3207
You may also email it to: shaffer_l@lasd.us

2018-2019
SACC Emergency Form
Lewisburg Area School District

Student's Name: ____

Birthdate: ___________________Gender: ______________________________________

Mailing Address: _________________________ City: ______________ State: ______ Zip: ________

Mother: __________________________________ Father: ______________________________

Mother's Address: _________________________ City: ______________ State: ______ Zip: _______

Father's Address: _________________________ City: ______________ State: ______ Zip: _______

Mother's Phone# _________________________ Father's Phone# _______________________

Mother's Employer: ________________________ Father's Employer: _____________________

If the school must contact a parent, please indicate first choice: __________________________

Emergency Contacts

In the event of an emergency or illness, the parent/guardian will be contacted first. Please list several other contacts, who can, in your behalf, discuss your child's health issues with school personnel, and/or can take your child home in the event that we cannot reach you.

Contact #1: _________________________ Phone: ___________________ Relationship: ____________

Contact #2: _________________________ Phone: ___________________ Relationship: ____________

Contact #3: _________________________ Phone: ___________________ Relationship: ____________

Family Healthcare Provider/Physician: ___________________________ Phone #: ________________

Hospital of choice: ____

The above information can be shared in emergency situations, during school sponsored trips, or as needed with school personnel involved with my child. I give permission to the staff at Lewisburg Area School District to transport or to make arrangements for the transportation of my child to emergency care and to sign permission for treatment declared necessary immediately by a physician in the event that the persons above cannot be reached.

Parent/Guardian Signature: ____Date:_________________

2018-2019
SACC Health Update Form
Lewisburg Area School District

Student's Name: ____

Birthdate: _____________________________ Gender: _____

Doctor's Name: ___________________________ Phone # _____________________

List all medications allergies: ____

List all food allergies: ____

Has your child ever needed emergency treatment for an insect/bee sting? ________

Does your child need a Special Diet? ____

List any Illnesses/Health concerns of your child: ____________________________________

Is your child under medical treatment for any of the above? __________________________

Has your child been admitted to the hospital in the past year? ________________________

If yes, please explain: ____

List the year of any diseases, operations, or major injuries your child has had:

____

Please list any medications your child takes at home: ________________________________

Please list any medications your child will need to take at school:

____

The above information is provided to ensure that my child will have a safe and healthy school experience.
At times, confidential information may need to be shared with others on a need to know basis. I give permission for this information to be shared if necessary with emergency/hospital personnel, chaperones during school sponsored trips, teachers, bus drivers, administration, counselors, playground/cafeteria aides, coaches, and/or as needed with other school personnel involved with my child. (Please circle those whom may not receive health information.)

Parent Signature: _______________________________________ Date: __________________

2018-2019
SACC Ambulance Permission Form
Lewisburg Area School District

In case of an emergency, LASD SACC program is required to have your permission to transport your child via ambulance.

Please complete the form below.

I, ____ give permission for
Parent's Name

my child, ____
Child's Name

to be transported via ambulance to ________________________hospital.
Hospital Name

We also require a copy of your child's latest Doctors visit

****A print out from your Doctor is acceptable****