

NEWTON CENTRAL SCHOOL
BEFORE AND AFTER SCHOOL CARE (BASC)
 Email: after-school.care@newton.school.nz
 Phone: 027-223-9629
 School: 09-378-6883



Mission Statement:

The Before and After School Care provides a safe, healthy environment and opportunities to participate in activities.

Part A: Enrolment Details

This document is an Enrolment Form (Part A) and a binding agreement (Part B) between: Newton Central School as the provider of the Before and After School Care programme and the parents or guardian of the children attending the program.

Starting Date:

End Date:

Child's full name:

Room No:

Parent's/Guardian's name:

Address:

Email:

Contact between 3pm to 6pm:

Home:

Work:

Mobile:

Alternative/Emergency Contact name:

Contact between 3pm to 6pm:

Home:

Work:

Mobile:

**Before school - Circle permanent days required
7am – 8.30am**

Mon

Tues

Wed

Thurs

Fri

After school - Circle permanent days required:

Mon

Tues

Wed

Thurs

Fri

After School - Circle session times per day:

3pm to 4pm

3pm to 5pm

3pm to 6pm

BEFORE SCHOOL AND AFTER SCHOOL CARE (BASC)

Part B: Agreement (please read carefully)

Please tick that you have read the terms and conditions and accept them. Please sign and date below.

- | | | |
|----|---|--------------------------|
| 1. | Before School and After School Care (BASC) is provided from 7.00am to 8.30am and 3.00pm until 6.00pm, Monday to Friday
• Permanent fees:
7.00am to 8.30am - \$5 per session (before 8.00am breakfast is available)
3.00pm to 4.00pm - \$10 per session (provision of snack and play supervision)
3.00pm to 5.00pm - \$15 per session (plus activities of sports or art/crafts)
3.00pm to 6.00pm - \$20 per session (students after 5.00pm will focus on home and academic work plus the above)
Any pick-up after 6.00pm will incur a \$15 late penalty
N.B: As we must employ staff in advance, changes or cancellations to bookings must be made 1 week in advance, or you will be charged the normal rate | <input type="checkbox"/> |
| 2. | I/We agree to make payment every four weeks in advance for use of the BASE. We prefer payments to be made automatically. The school bank account number is 12-3012-0751358-00 Reference CHILD'S NAME BASC 22250. | <input type="checkbox"/> |
| 3. | I/We understand that it is my/our sole responsibility to keep After School Care payments current and that the school will send regular statements and monitor the account status. | <input type="checkbox"/> |
| 4. | I/We understand that all costs incurred in the recovery of overdue funds including but not limited to debt recovery charges and legal fees may be added to the balance of my/our account. | <input type="checkbox"/> |
| 5. | I/We agree to notify the school by phone or email if student is unable to attend BASC as soon as possible. | <input type="checkbox"/> |
| 6. | I/We agree to inform the school immediately of any changes to the information provided on this form. | <input type="checkbox"/> |
| 7. | I/We understand that I/we will be informed as soon as possible of any emergency. | <input type="checkbox"/> |
| 8. | I/We understand that the BASC providers will take the utmost care to provide proper supervision for all children at each session. I/We also understand that in no event shall Newton Central School, its employees, management, trustees or BASC providers be liable for any loss or damage arising (by way of accident, injury, theft or otherwise) out of attendance at the BASC programme or in respect of any act of omission arising from any session or activity of the service. | <input type="checkbox"/> |
| 9. | I/We understand that either party may terminate this agreement on 15 working days notice. | <input type="checkbox"/> |

Name: _____

Signature: _____

Date: _____

MEDICAL INFORMATION

Emergency Contact if parents/guardians are unable to be contacted

Contact's Name:

Mobile Phone:

Home Phone:

Email Address:

Name of Doctor:

Phone Number of Doctor:

Does your child have any history of previous illnesses that may affect their enrolment, including mental illness?

Yes No

If 'Yes' please provide details: _____

Please tick the appropriate box(es) below if your child has suffered the following medical conditions:

Asthma Epilepsy Glandular Fever Migraines Diabetes

Allergies HIV or Aids Back/Neck Problems

Hepatitis A, B or C Heart Condition Tuberculosis ADD or ADHD

Eating Disorder Depression/Anxiety Allergy to Bee/Wasp Stings

Food Allergies (please state): _____

Other (Please state): _____

Does your child have any medical implants (such as metal implants) that may affect receiving medical treatment?

Yes No

If 'Yes' please provide details: _____

Is your child currently on any medication?

Yes No

If 'Yes' please provide details: _____

Please note: If your child suffers from conditions that require medication, it is advisable to bring your own medication.

Does your child have any special needs requirements e.g. one to one support, medication etc.?

Yes No

If 'Yes' please provide details: _____