



UNION-SCIOTO LOCAL SCHOOL DISTRICT

1565 Egypt Pike ♦ Chillicothe, OH 45601-3974 ♦ (740) 773-4102 ♦ FAX (740) 775-2852 www.unioto.org

"Today's Learners, Tomorrow's Leaders"

LATCHKEY PAYMENT INFORMATION

Latchkey fee is per month, there is not a daily or weekly rate.

A.M. Only – one child \$36.00 per month, additional child would be ½ price

P.M. Only – one child \$90.00 per month, additional child would be ½ price

A.M. and P.M. – one child \$110.00 per month, additional child would be ½ price.

ALL PAYMENTS ARE DUE BY THE 1ST OF EACH MONTH.

1. **The months of August, December and May are pro-rated so they are ½ of the monthly rate.**
2. **Please note that it is your responsibility to make your payments on time. Statements are not mailed. If payment is not received by the 1st of the month, your child may be removed from the latchkey program and a student from the waiting list will be admitted.**
3. **You are required to register your child each year for fall latchkey. Your child being enrolled in the current school year does not automatically enroll the student for the next school year. Applications must be turned in at the Superintendent's office.**

If you have any questions regarding your payments, please contact Karen Day at 740-773-4102.



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Pick-Up List

Name:	Relationship to Student(s)
1. _____	PARENT _____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____
11. _____	_____
12. _____	_____
13. _____	_____
14. _____	_____

*******Please note: Your child will not be permitted to leave with another latchkey parent if you do not have them listed on this form. You may alter the names to this list at anytime during the school year.**

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Latchkey Program and Procedures

Our latchkey program at Unioto Elementary is a safe and fun-filled environment to meet the needs of students and parents. We provide homework help, snacks, and activities to help your child be active and have fun before and after school.

The program's capacity is up to 80 children. You may enroll your child(ren) in latchkey at anytime of the year as long as there is still room available. You will need to complete everything in this packet and return it to the Superintendent's Office located in the Administrative Building. Administrative office hours are 7:30 – 3:30.

Your child will not be able to receive our services until the following papers are completed and returned:

- **Student registration**
- **Medical Emergency form**
- **Pick-up list**

The pick-up list is very important; please include any person that you think may be picking up your child. If a person comes to pick up your child and they are not on the list, your child will not be able to leave with them. The list can be changed throughout the year; just let us know if you would like to make any an adjustment to your pick-up list.

PARENTS OF OTHER LATCHKEY STUDENTS MAY NOT PICK UP YOUR CHILD IF THEY ARE NOT ON THE LIST.

After you have completed and turned in the forms, your child(ren) are ready to come to our program. If they are signed up for morning latchkey, you will be able to drop them off at 6:30 a.m. (no earlier) and you **MUST** sign your child in. They will be with Ms. Judy and she will dismiss them to begin their school day. We do not provide a breakfast or morning snack, however if you would like to send one with your child that would be fine.

The after-school latchkey starts at 2:40. All latchkey students will report to the cafeteria. Mrs. Sherry will take the kindergarten to wash up and then to the latchkey room to have snacks and work on activities. The rest of the students will wash up and have their snack and begin working on their homework or reading a book. Staff will sign they assigned group in and will help children with homework if they need it. After a brief study time, we dismiss into groups for activities or free time, (children are grouped by grade level). Our activities will include education, physical fitness, school-project related, and are always fun!!! By 4:30 the number of students has decreased and our groups are combined.

Our services end at 6:00 p.m. If you are late, we will wait in the latchkey room with your child. **Every minute past 6:00 will cost \$1.00** (note: all money must go the Superintendent's Office). **IMPORTANT: The child MUST be signed out by the person picking them up. THE SIGNOUT SHEET WILL ALWAYS BE WITH THE LATCHKEY DIRECTOR/STAFF, WHEREVER THE STUDENTS ARE.**

We are looking forward to a great year! If you have any questions regarding registration, fees or payments, feel free to contact Karen Day at 773-4102.

Kd/April 2019



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Emergency Medical Authorization Form

Purpose: To enable parents/guardians to authorize the provision of emergency treatment for students who become ill or injured while under school authority, when parent/guardian cannot be reached. Please also note all information on this form will be shared among staff to provide appropriate care of your student unless otherwise noted.

Student Information:

Student: _____ Grade: _____ DOB: _____ Male Female
 Address: _____
 Phone#: _____ Bus#: _____ Teacher/Homeroom: _____

Residential Parent/Guardian Information:

Mother:	Phone #:	Phone #:
Father:	Phone #:	Phone #:
Other:	Relationship:	Phone #:

If applicable, please list other children, grade and teacher within the district:

Permission for Over-The-Counter (OTC) Medication Administration (District will not provide OTC meds):

Parents need to provide OTC medications to the school. Dosage information is required.

Tylenol Dosage _____	Motrin Dosage _____	Tums Dosage _____	Benadryl-Oral/ Topical Dosage _____
Cough Drops Dosage _____	Antibiotic Ointment Dosage _____	Calamine Lotion Dosage _____	Hydrocortisone Cream Dosage _____

Signature of Parent/Guardian: _____ Date: _____

*It is the responsibility of the parent/guardian to notify school personnel if OTC medications have been given prior to arriving at school. By signing, this releases all school personnel of any liability related to performing this service to your child.

Other Pertinent Medical Information:

Yes, my child receives regular medical/health care for the following: No medical concerns

Seasonal Allergies	Bowel/Bladder Problems	Migraines
Asthma, Inhaler? <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	Seizures, Diastat? <input type="checkbox"/> Yes <input type="checkbox"/> No
ADD/ADHD, Medicated? <input type="checkbox"/> Yes <input type="checkbox"/> No	Cystic Fibrosis	Skin Conditions
Autism	Diabetes, Type I/II	Speech Problems
Behavior Concerns	Depression/Anxiety	Vision/Eye Problems
Bone/Muscle/Joint Concerns	Ear/Hearing Problems	Other:
Blood Problems	Heart Problems	Other:

Please explain any conditions above or any reasons for hospitalizations:

Is your child lactose intolerant? Yes No

Please indicate any allergies your child may have:

Bee /Insect	Reaction:	Epi-Pen <input type="checkbox"/> Yes <input type="checkbox"/> No
Food	Reaction:	Epi-Pen <input type="checkbox"/> Yes <input type="checkbox"/> No
Medication	Reaction:	Epi-Pen <input type="checkbox"/> Yes <input type="checkbox"/> No
Other	Reaction:	Epi-Pen <input type="checkbox"/> Yes <input type="checkbox"/> No

*If your child is lactose intolerant or has a food allergy, a Special Dietary Needs form must be completed to receive an alternate lunch/milk in the cafeteria. This form can be found on our school webpage.

Current prescribed medications:

Medication	Dosage	Frequency	Reason

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Prescription medication required during school? Yes No

*The Authorization for Administration of Prescription Medication form must be completed by physician and parent if your child requires prescription medication during school. All medication must be provided in the original bottle or package and will be stored in the clinic.

Does your child require any special procedures and/or treatments for their health concern? Yes No If yes, please explain:

Please indicate any other information about your child's health or development that you think would be helpful for the school to know:

Would you like to schedule a meeting with the school nurse? Yes No If yes, you will be contacted.

Emergency Treatment Part I and II:

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: (1) Administration of any treatment deemed necessary by the doctor listed below, or if the preferred practitioner is not available, by another licensed physician, dentist and (2) transfer my child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical options of two (2) licensed physicians or dentists, concurring in the necessity of the surgery, are obtained prior to the performance of such surgery.

Part I to Grant Consent:

I hereby give consent for the following medical providers and hospital to be contacted regarding my child (this consent also includes releasing immunization records to the school):

Child's Doctor:	City:	Phone #:
Child's Dentist:	City:	Phone #:
Specialist/Medical Condition:	City:	Phone #:

Signature of Parent/Guardian: _____ Date: _____

Part II Refusal to consent:

I DO NOT give my consent for emergency medical treatment of my child. In the event of an illness or injury requiring emergency medical treatment, I wish the school to take the following actions:

Signature of Parent/Guardian: _____ Date: _____

Field Trip Authorization:

I hereby give permission for my child _____ to participate in all school activities which involve field trips away from school grounds, provided such trips are an actual part of the school program.

Signature of Parent/Guardian: _____ Date: _____

Public Relations Consent:

I give my consent (or do not give consent) for audio, video, electronic images, student work, quotes, displays and photographs of my child with possible identification by full name and other personally identifiable information to be utilized by the Union-Scioto Local School District for exhibition, public display, publication, publicity materials, advertising, news media story, Internet, television, DVD and letter writing (pen-pal, thank you letters, letters to public officials, etc).

I give my consent I do not give my consent

Signature of Parent/Guardian: _____ Date: _____

Legal or Custody Issues:

Please list any legal or custody issues involving your child that you would like us to be aware of:

Form Completed By: _____ Signature: _____ Date: _____

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Authorization for Administration of Prescription Medications to Students

This form is required in compliance with the Board of Education and our school's policy. It must be completed in its entirety and returned to the school immediately before the prescribed medication can be dispensed.

Part A: To Be Completed by Medical Provider

Name of Student: _____ Grade: _____ DOB: _____

Medical Diagnosis: _____

Name of Prescription, Dosage, Route and Time of Administration at school: _____

Side Effects: _____

Is the student with asthma authorized to medicate himself/herself? Yes No

Date to start and finish medication: _____

Medical Provider's Name: _____ Phone #: _____

Address: _____

Signature of Medical Provider: _____ Date: _____

Part B: To Be Completed By Parent/Guardian

I request authorized school personnel to follow medical instruction requested in Part A. I understand and agree to:

1. To deliver the prescribed medication to school for my child.
2. To obtain a new authorization form for any type of change in medication, dosage, procedure and/or if the medication is to be stopped.
3. To obtain a new authorization form when there is a change in physician (even if the child is prescribed same medication).

I understand that school personnel are performing a service that is my responsibility. I release all school personnel of any liability related to performing this service, whenever reasonable cautions have been observed.

Parent/Guardian Name: _____ Phone#: _____

Signature of Parent/Guardian: _____ Date: _____

	Middle School	High School
Elementary		
138 Sandusky Blvd. Chillicothe, OH 45601 Phone #: (740) 773-4103 Fax: (740) 775-4074	160 Moundsville Road Chillicothe, OH 45601 Phone #: (740) 773-5211 Fax #: (740) 772-2974	14193 Pleasant Valley Road Chillicothe, OH 45601 Phone #: (740) 773-4105 Fax #: (740) 774-9158

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DATE:

Please complete and return to the Superintendent's office. This form must be on file in order for your child to remain in latchkey.

1. I _____ have registered _____ for

Parent
Student(s)

 fall latchkey for the 2018-2019 school year.
2. I understand that monthly payments are due on the 1st of each month. If payment is not received by the 1st of each month, my child will not be permitted to attend latchkey until the payment is received at the Superintendent's office. I understand that all payments are to go through the superintendent's office by using EZpay, bill pay or in person. Office hours are 7:30 a.m. - 3:30 p.m.
3. Electronics: Cell phones and tablets are permitted for games only. No calls or text messages are to be made while attending latchkey. If the students need to contact their parent, they should notify a latchkey employee. No videotaping is allowed during latchkey.
4. I understand that my child may be removed from latchkey for discipline issues.

Parent Signature

Date

Karen Day
1565 Egypt Pike
Chillicothe, OH 45601
kday@gotanks.org
740-773-4102

Matt Thornsberry, Superintendent

Karen Day, Secretary

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UNIOTO ELEMENTARY LATCHKEY PROGRAM

Unioto Elementary School
138 Sandusky Boulevard
Chillicothe, OH 45601

Superintendent's Office 740-773-4102 FAX 775-2852

LATCHKEY PROGRAM AGREEMENT AND REGISTRATION

Mail To: Superintendent's Office, attention Karen Day 1565 Egypt Pike Chillicothe, OH 45601

This agreement must be turned in to the Superintendent's Office prior to student attending latchkey.

Date: _____

Parent(s) Name: _____

Home Address: _____

Telephone Number: Home _____ Work: _____ Cell: _____

Emergency Contact (Other than parents): _____ Emerg. Contact Number _____

Student Name: _____ Grade for 2020-2021 _____

Student Name: _____ Grade for 2020-2021 _____

Student Name: _____ Grade for 2020-2021 _____

Registering for : 6:30 a.m.-8:00 a.m. only _____ 2:40-6:00 p.m. only _____

Both a.m. and p.m. _____

I certify by my signature that the information above is accurate. I have read and agree to abide by the parameters of the Unioto Elementary Latchkey Program. **I understand that I will be charged \$1 per minute for each minute after 6:00 p.m.** I agree to sign my child in upon arrival and sign him/her out at departure time providing proof of identity when requested. I further understand that if my child's behavior is such that it causes disruption to this program, latchkey services will no longer be provided. **I understand that if dual parenting is involved, the parent registering the child is ultimately responsible for latchkey payments.**

Parent/Guardian Signature: _____

For Office Use Only:

Received by: _____ Date: _____ Time: _____

Latchkey Director _____

Kd/April 2019

Matt Thornsberry, Superintendent

Karen Day, Secretary

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