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"

FALL LATCHKEY REGISTRATION

2021-2022

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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 and December are pro-rated due to only partial attendance during those months.**
2. **Please not that it is your responsibility to make your payments on time. Statements are not mailed. If payment is not received by the 1st of each month, your child may be removed from the latchkey program.**
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.**

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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 8:00 a.m.-3:00p.m..

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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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 2021-2022______________

Student Name:____Grade for 2021-2022______________

Student Name:____Grade for 2021-2022______________

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.***
Students must be potty trained.
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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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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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? □ Yes □ No		Cancer		Seizures, Diastat? □ Yes □ No
	ADD/ADHD, Medicated? □ Yes □ 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 □ Yes □ No
	Food	Reaction:	Epi-Pen □ Yes □ No
	Medication	Reaction:	Epi-Pen □ Yes □ No
	Other	Reaction:	Epi-Pen □ Yes □ 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 entirely 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: __________

Elementary
138 Sandusky Blvd.
Chillicothe, OH 45601
Phone #: (740) 773-4103
Fax: (740) 775-4074

Middle School
160 Moundsville Road
Chillicothe, OH 45601
Phone #: (740) 773-5211
Fax #: (740) 772-2974

High School
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 2021-2022 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 8:00 a.m.-3:00 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