

2019-2020 Club J Program and Tuition Rates

Two great after-school options - choose your experience!

Complete this Registration Packet and submit to

ClubJ@atlantajcc.org or deliver to MJCCA – CLUB J | 5342 Tilly Mill Road | Dunwoody, GA 30338

1. Club J Afterschool Program + Transportation

- Daily transportation from school to the MJCCA is included
- If transportation is not being used, drop off at the MJCCA begins at 2:30 pm
- \$50 non-refundable registration fee + \$150 deposit is due at time of registration
- Annual tuition is divided into 10 payments, billed monthly August 2019 – May 2020

*****EARLY-BIRD RATES THROUGH MAY 1, 2019*****

5 Days a Week - Annual Tuition is \$4,150 (**\$415/month**)

4 Days a Week - Annual Tuition is \$4,050 (**\$405/month**)

3 Days a Week - Annual Tuition is \$3,950 (**\$395/month**)

RATES AFTER MAY 1, 2019

5 Days a Week - Annual Tuition is \$4,200 (\$420/month)

4 Days a Week - Annual Tuition is \$4,100 (\$410/month)

3 Days a Week - Annual Tuition is \$4,000 (\$400/month)

2. Transportation Only

- Daily transportation from school to the MJCCA ONLY
- \$50 non-refundable one-time registration fee

TRANSPORTATION ONLY RATES

Unlimited Rides - \$190 per month

Single Ride - \$12 per ride

Transportation Included from the Following Schools: Atlanta Jewish Academy, Austin Elementary, Chesnut Elementary, The Davis Academy, Dunwoody Elementary, The Epstein School, Kingsley Charter Elementary, Montgomery Elementary, Peachtree Charter Middle School and Vanderlyn Elementary. **If your school is not listed, please call us to learn how we can add it!**

MJCCA Membership is required to attend Club J. For more information about membership, or to become a member, call us at 678.812.4060. To schedule a tour or speak with the Club J Director, contact us at 678.812.3761 or clubj@atlantajcc.org.

Payments will be processed on the 17th of each month. If the Business Office is closed, payments will be processed on the next business day.

Financial Assistance is available to MJCCA members. Priority will be given to the financial assistance applications that are submitted by **June 15, 2019**. Please contact Barbara Vahaba at Barbara.Vahaba@atlantajcc.org or 678-812-4142.

Cancellations must be given in writing with a two-week notice.

Please complete **ONE** form per child.

CHILD INFORMATION

Last Name		First Name		Siblings in the program	
Birthdate (mm/dd/yyyy)		<input type="checkbox"/> Male <input type="checkbox"/> Female		School _____ School Grade 2019-2020 <input type="checkbox"/> PK <input type="checkbox"/> K <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8	
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated		Child Lives With <input type="checkbox"/> Both Parents Jointly <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Both Parents Separately <input type="checkbox"/> Grandparents <input type="checkbox"/> Guardian		For Divorced Parents or Legal Guardians: Who has custody of this child? (Name)	

PARENT/GUARDIAN 1
PARENT/GUARDIAN 2

Name		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.		Name		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.	
Home Address				Home Address			
Home Phone # (<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary)		Cell Phone # (<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary)		Home Phone # (<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary)		Cell Phone # (<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary)	
Work Phone # (<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary)		Work Address		Work Phone # (<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary)		Work Address	
Email Address (please print)				Email Address (please print)			
Use as primary communication e-mail <input type="checkbox"/> Yes <input type="checkbox"/> No				Include in regular communication e-mails <input type="checkbox"/> Yes <input type="checkbox"/> No			
Grandparents' Names		Phone		Grandparents' Names		Phone	
May be released to Grandparents <input type="checkbox"/> Yes <input type="checkbox"/> No				May be released to Grandparents <input type="checkbox"/> Yes <input type="checkbox"/> No			

EMERGENCY CONTACTS: Individuals other than parents or grandparents whom we may contact and release the child to if parent cannot be reached.

 *Please note: Emergency contacts **must** live in Atlanta.

Name		Relationship		Home Phone _____ (<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary)		Address	
				Work Phone _____ (<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary)			
				Cell Phone _____ (<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary)			
Name		Relationship		Home Phone _____ (<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary)		Address	
				Work Phone _____ (<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary)			
				Cell Phone _____ (<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary)			

Additional Information

Does your child or has your child ever received any medical or educational therapies (PT, OT, Speech, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes", please list therapies: _____ Does your child have an IEP? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last therapy session: _____
How does your child get along with other children? <input type="checkbox"/> Easily <input type="checkbox"/> Fairly Easily <input type="checkbox"/> With Difficulty	
What behavior management methods work best for your child?	
Please share any information that you feel we should be aware of to best meet the needs of your child:	

Child's Last Name		Child's First Name		Date of Birth	
Address			Phone Number		
MEDICAL / IMMUNIZATION INFORMATION Please, note that Georgia Health Form #3231 is required for all children. Families new to Georgia may provide an official document equivalent to the GA 3231 immunization record. All records must be in English.					
Height		Weight		Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	
Chronic Medical Conditions <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", provide details.			Dietary needs or restrictions <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", provide details.		
Medicine or Food Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", a completed Allergy Form is required along with this form.			Any regular or PRN medicines <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", which ones?		
Does Child have any history of:					
Vision Impairment or eye infection		<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what? _____	
Hearing Impairment or ear infection		<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what? _____	
Speech problems		<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what? _____	
Rashes		<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what? _____	
Are any restrictions on normal physical activities indicated? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide details:					
Will medication be administered during Club J? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, an "Authorization to Dispense Medication" form, "Allergy Action Plan" form and/or "Authorization to Carry a Prescription, Inhaler, Epi-Pen or Insulin" form must be completed.					
Authorization for Treatment: Should the need for medical attention arise; (and in case of our unavailability), as parents or legal guardians, we want the MJCCA and/or staff to arrange and authorize medical treatment as necessary for our child. The MJCCA will use the nearest available hospital. Should specialist advice or treatment be required, our preferences are:					
Physician's Name (please print)		Physician's Address		Phone	
Child's Medical Insurance Co.		Group #		ID #	
In the absence of a parent or guardian, <input type="checkbox"/> I hereby give authorization or <input type="checkbox"/> I do not give authorization to the named emergency contact person to have access to my child's health information. (Please select choice above)					
This information is complete to the best of my knowledge.					
Parent/Legal Guardian Signature			Date		
Printed Name			Relationship		
Facility Administrator Signature			Date		

Sunscreen/Bug Spray/Topical Ointment

Please complete one per child

590-1-1-.20(1) - Georgia Bright From The Start

Parental Authorization

Except for first aid, personnel shall not dispense prescription or non-prescription medications to a child without specific written authorization from the child's physician or parent. Such authorization will include, when applicable, date; full name of the child; name of the medication; prescription number, if any; dosage; the dates to be given; the time of day to be dispensed; and signature of parent.

I give Club J at the MJCCA permission to apply one or more of the following topical ointments/preparations to my child in accordance with the directions on the label of the container.

_____ Bathroom Wipes

_____ Band-Aids

_____ Neosporin or similar ointment

_____ Bactine or similar first aid spray

_____ Sunscreen

_____ Insect Repellent

_____ Non-Prescription ointment (such as A & D, Desitin, Vaseline)

Other (please specify):

Child's Name

Parent/Guardian Signature

Date

Parents, please read and complete with your child.

I agree to follow the rules and behavior guidelines of the MJCCA and Club J. Program rules include, but are not limited to the following:

1. I will be respectful of my fellow participants and all program staff. This means that I will speak to others in a respectful manner and tone of voice, I will follow directions and I will not cause or threaten physical harm towards others. I understand that disrespectful behaviors include, but are not limited to, hitting, punching, kicking, biting, spitting, cursing, lying, stealing, inappropriate adult language/conversations and/or inappropriate physical contact and refusing to listen to the MJCCA and Club J staff.

2. I will be respectful of the Zaban Campus grounds, the Blank Family building and places we may visit and the belongings of others. This means that I will not litter, vandalize, steal or destroy items that do not belong to me.

3. I will not use or bring the following: matches and lighters; tobacco, alcohol and other drugs; firearms and other weapons (real or pretend). I understand that if I do, I may be asked to leave Club J for the remainder of the school year.

4. I will not bring anything to Club J that has value; including, but not limited to, Electronic game devices and games, trading cards, jewelry, cameras, etc. I understand that if I bring something of value, the MJCCA and Club J is not responsible if it is lost or damaged.

5. I agree to follow all Club J rules including those that are not listed on this behavior agreement.

Children: With a parent, I have read the Club J Attendee Agreement and I agree to follow the rules. I understand that not following these rules will result in consequences to my actions. In some cases, consequences may include suspension or dismissal from Club J.

Parents: By signing this document you are acknowledging that you have read and understand the rules listed above. Consequences may be imposed on your child at any time for failure to follow the behavior expectations outlined in this Attendee Agreement and the Parent Handbook.

Child's Name (printed) _____

Child (please have child write name) _____ Date _____

Parent/Guardian Signature _____ Date _____

PERMISSION TO PHOTOGRAPH

I hereby authorize the MJCCA to take, use, and publish photographs, video or audio recordings, or quotations from interviews of me/my family members which may be used for editorial, fundraising, and/or promotional and advertising purposes and in any manner and medium; and to alter and composite the same without restriction and without inspection or approval. I agree that there is to be no financial compensation for said use or publication, and hereby releases the MJCCA and persons functioning under its authority from all claims and liability relating to the same. **I understand that to revoke this photo/video/testimonial release, I must do so in writing to the Club J department at Clubj@atlantajcc.org.**

Parent/Guardian Signature: _____ Date _____

I have registered my child for: *(choose one)*

Club J Afterschool Program + Transportation (check all that apply)

___ *M* ___ *T* ___ *W* ___ *Th* ___ *F*

Transportation Only (check all that apply)

___ *M* ___ *T* ___ *W* ___ *Th* ___ *F*

Other – Describe special circumstances:

Transportation Permission

This is to certify that I give The Marcus Jewish Community Center of Atlanta via Club J permission to transport my child,
 _____ from _____ (*school*) at _____ pm and take my child to The Marcus
 Jewish Community Center of Atlanta at _____ pm.

My child **WILL** be transported on the MJCCA Club J Bus on the following days (*check all that apply*):

Monday

Tuesday

Wednesday

Thursday

Friday

In the event that my child is NOT to be transported on a regularly scheduled day, due to absence or early pick-up from school, I agree to notify Club J via e-mail at clubj@atlantajcc.org or telephone (678) 812-3761 prior to 12:00 pm the day of the change.

A **Registration Change Fee** of \$25 will be assessed for each change made from this Registration Form. Registration changes can be made by emailing clubj@atlantajcc.org and may take up to two weeks to process.

Parent/Guardian Signature _____ Date _____



All of the people listed below must be given your child's dismissal number, which will be sent to you prior to the start of the program. In the absence of the dismissal number, anyone picking up your child must have a valid driver's license or identification with them and their address must be listed below.

Please list the individuals that are authorized to pick up your child below.

Name	Relationship	Home Phone _____ (<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary)	Address
		Work Phone _____ (<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary)	
		Cell Phone _____ (<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary)	
Name	Relationship	Home Phone _____ (<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary)	Address
		Work Phone _____ (<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary)	
		Cell Phone _____ (<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary)	
Name	Relationship	Home Phone _____ (<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary)	Address
		Work Phone _____ (<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary)	
		Cell Phone _____ (<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary)	
Name	Relationship	Home Phone _____ (<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary)	Address
		Work Phone _____ (<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary)	
		Cell Phone _____ (<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary)	

The following individuals are NOT Authorized to pick up child:

Name	Relationship	Home Phone _____ Cell Phone _____	Address
Name	Relationship	Home Phone _____ Cell Phone _____	

Every child in Club J is assigned a dismissal number. Please only share this number with people that are picking up your child, as we will release your child to only those who have this number. If they do not have this number, AND they are not on the above list, your child will not be released into their care.

I realize that my child will not be released to anyone who does not have my child's dismissal number OR is NOT specified on my list. If an alternate person will be picking up my child, I will give them my child's dismissal number. Should they not know the dismissal number, the alternate person will not be permitted to leave with the child, until a parent is contacted and the pick-up is confirmed. A form of picture ID will be required from the individual picking the child up.

Parent/Guardian Signature _____ Date _____ Child's Name _____

At Club J, your child will have the opportunity to swim most Friday afternoons from 3:20pm – 4:15pm. In order for your child to swim, they must first pass a swim test which will be given by a Certified Lifeguard in our Aquatics Department. If your child is not an independent swimmer; e.g., cannot swim without the aid of floaties, noodles or water wings, then they will not pass the swim test, and therefore; not be able to swim at Club J. **You only need to sign this form if you intend to have your child swim tested.**

LICENSING REQUIREMENTS

If your child can swim, a swimming test must be given to determine whether the child can swim a distance of fifteen (15) yards, float on their back for 15 seconds and tread water for 30 seconds unassisted by a person who has current evidence of completing successfully a training program in lifeguarding offered by a certified water safety instructor.

I hereby grant permission for my child, _____ to be tested for their swimming ability. I will be notified if he/she passes and understand that the pool will be guarded by a WSI Certified Lifeguard at all times my child is in the water. I further understand that my child will not be granted permission to swim at the MJCCA if I have not also signed the MJCCA Waiver of Liability located on the Club J Emergency Contact/Health Form.

Name of Parent _____

Signature of Parent _____ Date _____

TO BE COMPLETED BY A LIFEGUARD

_____ has successfully completed a swimming test which required the child to swim a distance of fifteen (15) yards unassisted.

Below named Lifeguard has current evidence of having completed successfully a training program in lifeguarding offered by a water-safety instructor certified by the American Red Cross or YMCA or YWCA or other recognized standard-setting agency for water safety instruction.

Name of Lifeguard _____

Signature of Lifeguard _____ Date _____

Please fill this form out for each medication that you want dispensed for your child. A new form will need to be completed every two weeks.

Child's Last Name _____ Child's First Name _____

Parent/Guardian Last Name _____ Parent/Guardian First Name _____

All medication brought to Club J must be in its original bottle/container.

Name of medication _____ Dosage _____

Prescription # _____ Amount of medication to be dispensed _____

Time medication is to be given _____ Dates to be given _____

Parent/Guardian Signature _____ Date _____

FOR CLUB J USE ONLY

	DATE	TIME ADMINISTERED	AMOUNT	REACTIONS	ADMINISTERED BY
1				<input type="checkbox"/> Yes <input type="checkbox"/> No	
2				<input type="checkbox"/> Yes <input type="checkbox"/> No	
3				<input type="checkbox"/> Yes <input type="checkbox"/> No	
4				<input type="checkbox"/> Yes <input type="checkbox"/> No	
5				<input type="checkbox"/> Yes <input type="checkbox"/> No	
6				<input type="checkbox"/> Yes <input type="checkbox"/> No	
7				<input type="checkbox"/> Yes <input type="checkbox"/> No	
8				<input type="checkbox"/> Yes <input type="checkbox"/> No	
9				<input type="checkbox"/> Yes <input type="checkbox"/> No	
10				<input type="checkbox"/> Yes <input type="checkbox"/> No	

If noticeable adverse reaction to medication, what action was taken? Describe:

My Child will NOT need medication dispensed to them at CLUB J: _____

Parent Signature

Date

_____ needs to carry the following prescription labeled inhaler, EpiPen or insulin with him/her. The above named child has been instructed in the proper use of the medication and fully understands how to administer this medication.

Medication _____

Dosage _____ Directions _____

Physician's Signature & Stamp _____ Date _____

I have been instructed in the proper use of my prescription labeled medication and fully understand how to administer this medication. I will not allow another child to use my medication under any circumstances. I also understand that should another child use my prescription, the privilege of carrying my medication may be revoked. I also accept the responsibility for checking in with the staff to keep them informed of use of my medication in case I start having problems.

Child's Signature _____ Date _____

I hereby request that the above named child, over whom I have legal control, be allowed to carry and use the prescription medication described above, at this program. I accept legal responsibility should the above medication be lost, given or taken by a person other than the above named child. I understand that if this should happen, the privilege of carrying the medication may be revoked, I hereby absolutely and fully release The Marcus Jewish Community Center of Atlanta, Inc., its officers, directors, employees, members, and agents from any legal responsibility whatsoever when the above named camper administers his/her own medication. My child and I recognize that the employees of the MJCCA are not responsible for reminding my child to use his/her inhaler, EpiPen or insulin.

Parent/Guardian Signature _____ Date _____

**PLEASE INITIAL HERE IF THIS IS NOT APPLICABLE TO YOUR CHILD: _____

Child's Last Name	Child's First Name	Date of Birth
Parent/Guardian Last Name		Parent/Guardian First Name
Allergy to		Asthmatic <input type="checkbox"/> Yes (Higher risk) <input type="checkbox"/> No

STEP 1: TREATMENT
SYMPTOMS

- If a food allergen has been ingested, but *no symptoms*:
- Mouth - *Itching, tingling, or swelling of lips, tongue, mouth*
- Skin - *Hives, itchy rash, swelling of the face or extremities*
- Gut - *Nausea, abdominal cramps, vomiting, diarrhea*
- Throat[†] - *Tightening of throat, hoarseness, hacking cough*
- Lung[†] - *Shortness of breath, repetitive coughing, wheezing*
- Heart[†] - *Thready pulse, low blood pressure, fainting, pale, blueness*
- Other[†] _____
- If reaction is progressing (several of the above areas affected), give

GIVE CHECKED MEDICATION

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |

The severity of symptoms can quickly change. [†]Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg

Antihistamine: give _____
medication/dose/route

Other: give _____
medication/dose/route

STEP 2: EMERGENCY CALLS

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ at _____

3. Emergency contacts:

Last Name _____ First Name _____

Home # _____ Cell # _____ Relationship _____

Last Name _____ First Name _____

Home # _____ Cell # _____ Relationship _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____

****PLEASE INITIAL HERE IF THIS IS NOT APPLICABLE TO YOUR CHILD:** _____

This form will be kept on your child's bus.

Child's Name _____ Date of Birth _____

Address _____

Father's Name _____

Home Phone _____ Work Phone _____

Mother's Name _____

Home Phone _____ Work Phone _____

Person to notify in an emergency and parents cannot be reached:

Name _____ Phone _____

Child's Doctor _____ Phone _____

Medical facility the center uses _____

Address _____

Child's Allergies _____

Current prescribed medication _____

Child's special needs and conditions _____

In the event of an emergency involving my child, and if Club J cannot get in touch with me, I hereby authorize any needed emergency medical care. I further agree to be fully responsible for all medical expenses incurred during the treatment of my child.

Child's Name _____

Signature (Parent/Guardian) _____

Witness By _____ Date _____