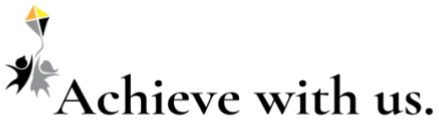

TLC After-School Care Program Contract

This After-School Care Program Contract ("Contract") is made and entered into on this _____ day of _____, ***20***___, by and between **The Arc of the St. Johns** ("TLC After-School Care"), and the undersigned parent(s)/guardian(s) ("Parent/Guardian") of _____ ("Student").

1. Program Overview
The TLC After-School Care Program provided by The Arc of the St. Johns is offered exclusively to currently enrolled students of The Therapeutic Learning Center who are at least three (3) years of age. The Program operates Monday – Friday 2:00 pm – 5:00 pm in accordance with the **St. Johns County School District (SJCSD) Master Calendar**, including all scheduled closures and makeup days if applicable. Program hours subject to change. Space is limited.

2. Payment Structure
The Parent/Guardian agrees to pay for the Program based on one of the following payment options:

Choose Billing (please select one and initial):

☐ Monthly Payment: $300 per month _____

☐ Bi-Weekly Payment: $150 every two weeks _____

☐ Weekly Payment: $75 per week _____

3. Payment Terms & Automatic Billing

- The Parent/Guardian agrees to **provide and maintain a valid Debit or credit card on file**. Failure to update payment information within **48 hours** of a failed transaction will result in service suspension until a valid payment method is provided.

- Parent/Guardian agrees **The Arc of the St. Johns** will automatically **charge the payment method on file** based on the payment plan selected. Payments are due in advance of services. Payments will be automatically processed on the first business day of the agreed upon payment schedule as selected in section 2 of this agreement.
- Payments are **non-refundable** and remain due regardless of absences or school closures, as school breaks and closures are factored into pricing. Exceptions may be considered for extended medical absences or emergency school closures at the discretion of the Program.

4. Late or Non-Payment Consequences

- If a payment fails, the Parent/Guardian will be notified and required to update their payment method within **48 hours** to avoid service disruption.
- **Seriously delinquent payments (1 Month of missed payments)** will result in **suspension from the After-School Care Program roster**, and re-enrollment will be subject to availability and full settlement of outstanding balances. Parent/Guardian remains responsible for outstanding balances after suspension of services and or permanent removal from program.

5. Term & Termination

- This Contract automatically renews at the end of each academic year unless the Parent/Guardian formally withdraws the student from the After-School Care Program, or the student is no longer enrolled in The Therapeutic Learning Center. Notice may be provided by email to Lbrannan@arcsj.org.
- The Arc of the St. Johns reserves the right to terminate this Contract due to non-payment, non-compliance with Program rules, or other disciplinary reasons.

6. Acknowledgment & Agreement

By signing below, the Parent/Guardian acknowledges and agrees to the terms of this Contract, including the automatic payment authorization and consequences of non-payment.

Parent/Guardian Name: _____

Signature: _____

Date: _____

Billing Information

(used for printed agreements)

Credit or Debit Card: ☐ Visa ☐ Mastercard ☐ American Express ☐ Discover

Name on Account: _____

Credit Card #_____

Billing Address: _____

_____

CVC #_____Expiration Date: _____

Choose Billing (please select one and initial):

☐ Monthly Payment: $300 per month _____

☐ Bi-Weekly Payment: $150 every two weeks _____

☐ Weekly Payment: $75 per week _____

By signing this document, I confirm that this payment is valid and authorize The Arc of the St. Johns to process automatic transactions based on the selected payment option.

Name (must match name on credit/debit card): _____

Signature: _____

After-School Program Rules & Information:

The TLC After-School Care Program provided by The Arc of the St. Johns is offered exclusively to currently enrolled students of The Therapeutic Learning Center who are at least three (3) years of age. The Program operates Monday – Friday 2:00 pm – 5:00 pm in accordance with the **St. Johns County School District (SJCSD) Master Calendar**, including all scheduled closures and makeup days if applicable. Program hours subject to change. Space is limited.

The **TLC After-School Program** is an extension of our education program focused on structured and unstructured **play-based learning** in a safe and loving **therapeutic environment** with **low student-to-staff ratios** utilizing **early education themes**.

- **Snacks:** Please send **extra snacks** for children enrolled in after-school care to accommodate their extended day.
- **Diapers/Wipes:** Parent or Guardian will provide necessary toileting supplies
- **Private Therapy:** Parents may hire private therapists to provide services during after-school hours. Please contact the **Director of Children's Services** to review **Private Instructional Personnel (PIP) requirements and submit requests for approval**.

Pick-Up & Safety Policies:

- **Pick-up time is 5:00 PM** (pick up time subject to change with notice when required).
- **Frequent late pick-ups** may result in additional fees or program suspension.
- **Pick-up location:**
    - **Main entrance** – park in the lot or under the awning. Do **not** block the fire lane.
- **Authorized Pick-Ups Only:**
    - Students will only be released to **approved adults**.
    - **ID verification** may be required.
    - We will **not** release students to individuals who are impaired or under the influence.
    - We will **not** release students to individuals under 18 unless they are the legal parent/guardian.
    - The pick-up person must have an **appropriate safety seat** in their vehicle.
- **Changes in Pick-Up Arrangements:** Parents must **notify staff in advance** if someone else is picking up their child. Notification: Class Dojo, Staff & Director, Lauren Brannan 904-401-0641. Please note, the TLC phone line is not a prompt contact option after regular school hours.
- **Illness Policy**
    - A student with a temperature above normal or who is exhibiting other signs of illness shall be evaluated by the school staff and sent home.

Parent Expectations:

- **All applicable policies as stated in the parent handbook extend to the After-School program**
- **Timely payments** and adherence to the selected billing schedule.
- **Prompt pick-ups** and clear communication with staff regarding any concerns.
- **Updated emergency contact information** and authorization for **medical treatment**.

HEALTH SERVICES

Medication Administration

AUTHORIZATION TO ASSIST IN THE ADMINISTRATION OF MEDICATION/TREATMENT

Student Name: _____ Date of Birth: _____

School: Therapeutic Learning Center Teacher: _____

List Known ALLERGIES: _____

NURSING SERVICES AND MEDICATION/TREATMENT ORDER

ALL INFORMATION MUST MATCH THE PRESCRIPTION LABEL! All medication must be properly labeled and in original containers. Complete one form for each medication/treatment to be administered. A new form must be completed if the dosage of a medication changes at any time.

Nursing services are recommended for the care of this student during the school day.

It is necessary for the following medication/treatment to be given in school and during school sponsored activities. I am aware that non-medical personnel may administer this medication/treatment.

Name of medication/treatment: _____ **Amount (Dosage):** _____

Time to be given: _____ **Date to start:** _____ **Date to end:** _____

Health condition requiring medication: _____

Possible side effects: _____

Special instructions: _____

Physician ordering medication: _____

(please print)

Physician address: _____

Physician's phone: **Fax:**

Physician's signature: (required for all medications) _____ **Date:** _____

PARENT/GUARDIAN to Complete: Authorization for Health Care Provider and School Staff to Share Information

I authorize my child's school staff to assess my child as regards his/her special health care needs and to discuss these needs with my child's physician as needed throughout the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually.

As the parent or guardian of the student named above, I request that the Director, Director's designee, Therapy, or Teaching Staff assist in the administration of medication/treatment prescribed for my child.

I understand that under provisions of Florida Statue 1006.062, there shall be no liability for civil damages as a result of the administration of medication when the person administrating such medication acts as an ordinarily reasonable, prudent person would have acted under the same or similar circumstances. I also grant permission for school personnel to contact the physician listed above if there are any questions or concerns about the medication. I have read the guidelines and agree to abide by them. I authorize the physician to release information about this condition to school personnel.

Parent/Guardian Signature	Print Name	Phone Number	Date

EMERGENCY MEDICATION (INHALER ☐/EPINEPHRINE ☐)—

Emergency Medication provided by parent will remain at school School/After-School/Therapy, or other trained staff may administer emergency medication to the above named child.

Parent/Guardian signature: (required) _____ Date: _____

Physician's Signature: (required) _____ Date _____

CONSENT FOR EMERGENCY MEDICAL ATTENTION

I hereby give staff of The Therapeutic Learning Center and The Arc of the St. Johns permission to see that emergency medical treatment is given in the situation that such is required and I am not available for the consent at the time. Emergency medical treatment will be obtained at the nearest hospital.

911 will be called in any medical emergency that requires more than just basic first aid treatment.

If your child has a specific medical condition that requires a Physicians' Medical Plan, please provide a copy to the school.

Consent to dispense any medication must be submitted in writing to the school.

I have an authorization to assist with medication on file? YES☐ NO☐

EpiPen ☐ Inhaler ☐ provided by parent in case of emergency?

_____ _____

Student Name Custodial Parent/guardian name

_____ _____

Date Custodial Parent/guardian signature

TLC The Arc of the St. Johns
After School Care

Emergency Contact/Authorized Pick-Up Person Form

Please list anyone who may be contacted to care for your child if a parent cannot be reached in an emergency, and anyone authorized to pick up your child from TLC After School Care. Please note only those listed below will be authorized to pick up your child, unless you add them and sign a new document.

EpiPen? ☐ **Yes** ☐ **No** **History of Seizures?** ☐ **Yes** ☐ **No**

Allergies:_____

Medication/Dosage:_____

Custodial Parent(s)/Legal Guardian(s):_____

Address:_____City:_____Zip:_____

Phone:_____

Medical Insurance Company:_____

Policy #:_____

Emergency Contact (if custodial parent/guardian cannot be reached):

Name:	Relationship:	Phone:	Emergency	Pick-Up:
_____	_____	_____	☐	☐
_____	_____	_____	☐	☐
_____	_____	_____	☐	☐
_____	_____	_____	☐	☐
_____	_____	_____	☐	☐
_____	_____	_____	☐	☐
_____	_____	_____	☐	☐

Child's Name: _____

Custodial Parent(s)/Legal Guardian: _____

Signature: _____

Date: _____

UPDATED

DATE: _____ SIGNATURE: _____

DATE: _____ SIGNATURE: _____

DATE: _____ SIGNATURE: _____

DATE: _____ SIGNATURE: _____

DATE: _____ SIGNATURE: _____