

# Matawan-Aberdeen Regional School District



**OFFICE OF CURRICULUM & INSTRUCTION**  
**One Crest Way**  
**Aberdeen, New Jersey, 07747**  
**(732) 705-4020 FAX (732) 290-0751**

*Dr. Joseph G. Majka*  
 Superintendent of Schools

*Dr. Karen Jones*  
 Assistant Superintendent of Curriculum & Instruction  
*John Bombardier*  
 Director K-12 Instruction & Evaluation  
*Celestine J. Zitarosa*  
 Director of K-12 Language Arts Literacy/Humanities

## 2016 – 2017 Preschool And Wrap Program (PAW) Registration Form

### CHILD INFORMATION

Last Name (Child)	First Name	Birth Date	School	Grade Fall 2016	Gender M/F

### AM WRAP

Check	Fixed Days Per Week	Monthly Fee	Qualify for Free/Reduced
	<b>3 DAYS</b>	<b>\$150.00</b>	<b>\$135.00</b>
	<b>4 DAYS</b>	<b>\$175.00</b>	<b>\$158.00</b>
	<b>5 DAYS</b>	<b>\$200.00</b>	<b>\$180.00</b>

### PM WRAP

Check	Fixed Days Per Week	Monthly Fee	Qualify for Free/Reduced
	<b>3 DAYS</b>	<b>\$150.00</b>	<b>\$135.00</b>
	<b>4 DAYS</b>	<b>\$175.00</b>	<b>\$158.00</b>
	<b>5 DAYS</b>	<b>\$200.00</b>	<b>\$180.00</b>

Payment is due the 15<sup>th</sup> of every month (10 equal payments per school year)

**Busing is \$500.00 per student per year. Please circle if you child will be taking a bus.**

**YES**

**NO**

**FAMILY INFORMATION**

	<b>Parent/Guardian #1</b>	<b>Parent/Guardian #2</b>
Name		
Home Address		
City, State, Zip		
Home Phone		
Cell Phone		
Work Phone		
Employer		
Employer City, State		
Email Address		
Custody Restrictions?	NO YES: attach copy of most recent order	Comments:

**Emergency/Alternate Contact & Authorized Pick Up:** If parent/guardian cannot be reached in the event of an emergency, the following person(s) will be contacted. Contacts are expected to act on behalf of the parent/guardian; parental permission to pick up child is implied. Contacts should be available during the hours of your child/children attend the PAW program.

*\*\*Please list in order of importance.*

<b>Call</b>	<b>Full Name</b>	<b>Relationship to Child</b>	<b>Best Contact Number</b>
<b>First</b>			
<b>Second</b>			
<b>Third</b>			

**Care Information:** Please state information you feel would be useful in meeting your child’s needs:

**Allergies/Medical Conditions/Disabilities/Medications:**

**Social/emotional/speech/language/academic/family situations:**

**Medical Permission:** If a medical emergency arises, the PAW staff will contact:

1. PAW Director
2. Parent/Guardian
3. Emergency Contacts

If a medical assistance is deemed necessary, professional emergency personnel may treat my child. I give permission for said emergency personnel to access to my child’s health plan. MARSD provides secondary coverage if an accident or injury occurs while participating in MARSD PAW programs.

\_\_\_\_\_

**Parent/Guardian Signature** **Date**

**Hospital Preference:** \_\_\_\_\_

\_\_\_\_\_

**Child’s Physician Name/Phone** **Child’s Primary Insurance Co. & Policy #**

**PLEASE RETURN COMPLETED FORM TO  
CAMBRIDGE PARK PRESCHOOL MAIN OFFICE**