Immaculate Heart of Mary School
LINX Program
2859 Lillis Drive
Cuyahoga Falls, Ohio 44223
Phone: 923-1220 ext. 1110

Objective:

To meet the need for a safe after school environment for the children of IHM school.
To let the student experience **L**earning, **I**magination, **N**utrition and e**X**ercise.

Hours: 2:45 p.m. – 6:00 p.m.

Schedule:

The program will consist of snack time, recreational activities, arts and crafts, time for homework, free time and, weather permitting, outdoor play. **The snack will be provided by parents for their own child.**

Finances:

Children	2:45 – 3:45 p.m.	2:45 – 4:45 p.m.	2:45 – 6:00 p.m.
1	$8.00	$12.00	$14.00
2	$11.00	$16.00	$20.00
3	$13.00	$18.00	$23.00

Our current FACTS TUITION MANAGEMENT SERVICE is handling the entire billing and collection process. **Payments will be made directly to FACTS with quick and easy on-line payment options, including "auto-pay" if you so choose.**

You should already have a FACTS account registered with the school. Now is a good time to log into your account at www.factsmgt.com to make sure all of your information is current.

You will receive monthly invoices via e-mail. If you do not have an active e-mail address associated with your FACTS account, you will receive a bill in the mail. **You will no longer receive a paper invoice from the school nor should any remittance be returned to the school.** *Please note: Invoices that are not paid within 30 days of the due date will incur a fee.*

IHM LINX Program
LINX Registration

Registration Fee: $15.00 per family. (**Charged to FACTS- Applied first month of LINX billing)**

(PLEASE PRINT)

Child's Name	Sex	Age	Grade (Aug. 2020)
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____

Parent(s)/Guardian _____

Address _____ Zip Code _____

City/Zip _____

Home Phone _____

Check the days your child will be attending LINX and indicate approximate pick-up time

_____Mon. _____Tues. _____Wed. _____Thurs. _____Fri.

Pick-up Time: _____Mon. _____Tues. _____Wed. _____Thurs. _____Fri.

If you plan to use this service on an occasional basis, please indicate how often you will use this service.

_____ Once a week _____ Twice a week

_____ Three times a week _____ Emergency only

_____ Times monthly

A late fee of $5.00 for every 15 minutes will be charged after 6:00 p.m.

IHM LINX Program
Child Pick-Up Authorization

Name of child/children:

_____ _____

_____ _____

_____ _____

The following person(s) have my authorization for pick up my child/children from the IHM LINX Program:

Name of Adult	Relationship to Child
Name of Adult	Relationship to Child
Name of Adult	Relationship to Child
Name of Adult	Relationship to Child

The sign-out sheet must be signed by the parent or designated adult each day at the time of the child's dismissal. All individuals must bring with them a photo I.D.

I understand that the above named person(s) are designated to pick up my child/children. In the event that another person is going to pick up my child/children at any time, I will send a message, in writing, prior to the pick-up time.

Parent Signature: _____ Date: _____

IHM LINX Program
2020-2021 Medical/Emergency Information

Please Print Clearly:

Child's Name_____

Child's Name_____

Child's Name_____

Father's Name _____

Home Address _____ **City/Zip** _____

Home Phone _____ **Cell/Business** _____

Mother's Name _____

Home Address _____ **City/Zip** _____

Home Phone _____ **Cell/Business** _____

If parents cannot be reached in the event of an emergency, please contact:

Name **Phone** **Relationship**

_____

_____

_____

List all allergies (including food) and any special precautions or treatment indicated for these allergies:

_____

_____

_____

IHM LINX Program
2020-2021 Medical/Emergency Information

List any medications currently being administered to the child:

_____

_____

_____

List any chronic physical problems and history of hospitalization:

_____

_____

_____

Parent Signature: _____ Date: _____

IHM LINX Program
Emergency Medical Authorization

Please Print Clearly:

Child's Name **Birthday** **Age** **Grade** (Aug. 2020)

_____

_____

_____

Address: _____

Phone: _____

Part I or II must be completed:

Part I (TO GRANT CONSENT)

In the event reasonable attempts to contact me at _____ (phone number) or _____ (other parent) at _____ (phone number) have been unsuccessful, I hereby give my consent for:

1) the administration of any treatment deemed necessary by: Dr. _____ (preferred Doctor) at _____ (phone number) or Dr. _____ (preferred Dentist) at _____ (phone number) or in the event the designated preferred practitioner is not available, by another licenses physician or dentist; and 2) the transfer of the child to _____ (preferred hospital) or any hospital reasonably accessible.

This authority does not cover major surgery unless the medical opinions of 2 other licensed physicians or dentists, concurring in the necessity for such surgery are obtained before the surgery is performed. Facts concerning the child's medical history including allergies, medications being take, and any physical impairments to which a physician should be alerted:

_____

_____

_____

_____ _____ _____

Date **Signature of Parent** **Address**

IHM LINX Program
Emergency Medical Authorization

DO NOT COMPLETE PART II IF YOU COMPLETED PART 1

Part II (REFUSAL TO CONSENT)

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to:

_____

_____	_____	_____
Date	**Signature of Parent**	**Address**