



Registration 2016-2017

Child's Name: First: Last:

Address: City: Zip:

Home Phone: DOB: Age Grade:

School School Town Gender Male Female

Parent A Parent B

Occupation Occupation

Business Name Business Name

Business Phone Business Phone

Cell Phone Cell Phone

Email

Days of Week Attending 16/17: (circle days) Monday Tuesday Wednesday Thursday Friday

Doctor Name Phone Number

Allergies

In Case of emergency, if parent is not available, the JCC may call:

Name	Name
Phone	Phone
Relationship	Relationship

Dismissal Options (choose one):

_____ I understand this program ends promptly at 6:00 pm. I have made necessary emergency pick-up arrangements should I be late. **I understand that I will be billed \$5 per minute per child for any time he/she remains after 6:00 pm.**

_____ I will need extended hours coverage from 6:00 -6:30 pm at an additional fee.

Signature of Parent or Guardian

Date

**Please return completed form with a \$200 check to:
JCC MetroWest, 760 Northfield Avenue, West Orange, NJ 07052
For further information call Susan Hur, 973-530-3465
or email shur@jccmetrowest.org**



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760 Northfield Avenue
West Orange, New Jersey 07052

BOTH SIDES MUST BE COMPLETED

PAYMENT OPTION FORM* (complete both sides)

Membership # _____ Last Name _____ First Name _____

Home Address _____ Apt. No. _____ Home Phone () _____

City _____ State _____ Zip _____

Fees can be paid by choosing one of the following:

Option 1: Monthly Credit Card

We will automatically charge your credit card account with the amount of your monthly Nursery on the first of each month.

VISA AMX MC Number _____ Exp. Date _____

Name on card _____ Signature _____ Date _____

Option 2: Electronic Transfer

This is an automatic withdrawal from your checking account. On the fifteenth of each month we will ask your bank to transfer the amount of your monthly Early Childhood fee to the JCC's account.

A voided check will be required to set up this option.

Authorization Agreement for Pre-Arranged Payments (Debits)

I(we) hereby authorize JCC MetroWest, hereinafter called COMPANY, to initiate debit entries to my (our) account indicated below and the Bank named below, hereinafter called BANK, to debit the same to such account.

Bank _____ Branch _____

City _____ State _____ Zip _____

Account Number _____

This authority is to remain in full force and effect until COMPANY and BANK have received written notification from me(or either of us) of its termination in such time and in such manner as to afford COMPANY and BANK a reasonable opportunity to act upon it. I (or either of us) has the right to stop payment of a debit entry by notification to BANK at such time as to afford BANK a reasonable opportunity to act upon it prior to charging account. After account has been charged, I have the right to have the amount of an erroneous debit immediately credited to my account by BANK, provided I (we) send written notice of such debit entry in error to BANK within 15 days following issuance of the account statement and/or 45 days after posting, whichever occurs first.

Name(s) _____

Signed _____ Date _____

Signed _____ Date _____

PLEASE STAPLE A VOIDED CHECK TO THIS FORM

* Other than payment in full by check/cash

SEE OTHER SIDE FOR PAYMENT SCHEDULE