WELCOME TO
THE P.A.L. PROGRAM!

Non-Profit Before and After School Childcare Program

Serving Kindergarten through age twelve students in the York School District

2026 – 2027
REGISTRATION PACKET

P.A.L. Program Co-Directors:

Nancy Conrad – Registrations/questions & concerns/changes
ThePALprogram@gmail.com

Laura Gilchrest – Billing & Financial Aid questions
LauraGilchrest.PAL@gmail.com

POLICY CHANGES TO NOTE:

The following fees/policies have been updated for the 2026-2027 school year:

REGISTRATION & SECURITY DEPOSIT FEE –

*REGISTRATION FEE: $100.00 *($20.00 per additional child)* non-refundable fee.
*REFUNDABLE TUITION SECURITY DEPOSIT: $100.00 per family, regardless of date enrolled.

The Registration fee and Tuition Security Deposit will be automatically charged to your account on file within two weeks of your spot being confirmed. The first week's tuition will be charged the Friday prior to your child's start date at PAL.

TUITION FEES – MORNING PROGRAM – VES/CRES/Middle Weekly Tuition: $100
AFTERNOON PROGRAM – VES/CRES/Middle Weekly Tuition: $175 *(includes snack)*

LATE FEES – First time being late, $5.00 per family per minute after 6pm. Second time late, the charge doubles to $10.00 per family per minute after 6pm & suspension of care may be discussed by the Co-Directors.

FUNDRAISER OBLIGATION – $200 per school year

MIDDLE SCHOOL SESSION – Our afternoon Middle School Session is subject to cancellation if enrollment numbers drop below a level that is financially sustainable to operate. In the event that the Middle School session must be discontinued, we will provide a two-week notice.

ATTENDANCE REMINDER: If your child will not be attending the afternoon program for any reason – or needs to be added to a day, you must call 207-363-1441 to notify us prior to 1:45pm. Leave us a voicemail on our P.A.L. phone. ***DO NOT email changes; emails are not an acceptable form of notification of schedule changes***. There is a $10.00 no-call fee each time you do not notify us by phone of these types of changes.

SAVE $106 this school year!

Choose to set up your PAL account with a Savings or Checking account and **SAVE $3** per week *(afternoon session only)*

Benefits of using your Savings or Checking account, instead of your credit or debit card:

- You would not incur any NSF fees due to expired credit/debit cards.
- You save $3 per week, which equals to $106 savings for the 26-27 School/PAL year!

Please contact Laura Gilchrest if you have any questions! LauraGilchrest.PAL@gmail.com

REGISTRATIONS DUE BY AUGUST 3rd

2026-2027

P.A.L. must receive your registration form on or before AUGUST 3, 2026 in order for your child to attend the program at the beginning of the 26/27 school year (subject to availability). After this date, we will accept additional registrations based on availability and you may be placed on a waiting list.

Spaces are limited; availability is not guaranteed until you receive a confirmation email.

TO DO:

• Read the Parent Policies / Handbook

Found on our website: www.palprogramyork.com

• Fill out Registration Form.

Your spot will not be confirmed until we receive
ALL required information and documents.

• Email Registration Form to:

ThePALprogram@gmail.com

Be sure to include the following documents:

- ☐ **Tuition Express Form**
- ☐ **Immunization Record** *(from birth to present)*
- ☐ **Allergy-Asthma-Anaphylaxis Forms**
  (if applicable – must be signed by child's physician)
- ☐ **Middle School "Walk to PAL" Form** *(if applicable)*

THE NEXT STEPS:

- You will receive an email response once your forms have been reviewed.
  (If anything is missing, your spot will not be confirmed until you send in ALL required info and documents).
- Once we have received **completed forms and all required documents**, you will receive a confirmation email stating your spot in the program is secured OR wait listed.
- PLEASE NOTE: The Registration fee & Tuition Security Deposit will be automatically charged to your account on file within two weeks of your spot being confirmed. First week's tuition will be charged the Friday prior to your child's start date at PAL. Thank you!

The P.A.L. Program • 2026-2027 Registration Form

❖ *All information is required before your child may attend* ❖

Child Information

Child's Full Name: **D.O.B:** ☐ Female ☐ Male

Physical Address:

School: ☐ V.E.S. ☐ C.R.E.S. ☐ MIDDLE **Teacher:** **Grade:** **P.M. Bus #:**

CONTRACTED Parent/Guardian Information (First Emergency Contact)

***All names on registration form MUST match valid State or Federal Photo Identification ***

Full Name: _____ **D.O.B:** _____ **Relation to Child:** _____

SSN: _____ **Email Address:** _____

(Billing info & E-Newsletters sent here!)

Physical Address: _____ _____ _____

(Street) *(City / State)* *(Zip Code)*

Mailing Address: _____ _____ _____

(Street / PO Box) *(City / State)* *(Zip Code)*

Home Phone: _____ **Cell Phone:** _____

Work Place: _____ **Work Phone:** _____

Physical Address: _____ _____ _____

(Street) *(City / State)* *(Zip Code)*

Second Parent/Guardian Information (Second Emergency Contact)

Full Name: _____ **D.O.B:** _____ **Relation to Child:** _____

SSN: _____ **Email Address:** _____

(E-Newsletters sent here!)

Physical Address: _____ _____ _____

(Street) *(City / State)* *(Zip Code)*

Mailing Address: _____ _____ _____

(Street / PO Box) *(City / State)* *(Zip Code)*

Home Phone: _____ **Cell Phone:** _____

Work Place: _____ **Work Phone:** _____

Physical Address: _____ _____ _____

(Street) *(City / State)* *(Zip Code)*

Alternate Pick-Up List

Names of Person(s) on your pick-up list MUST match their valid State or Federal Photo Identification

Full Name: **Phone Number(s):**
Physical Address:

Full Name: **Phone Number(s):**
Physical Address:

Full Name: **Phone Number(s):**
Physical Address:

The P.A.L. Program • 2026-2027 Registration Form

Medical Information for: _____
Child's Name

To help ensure that your child is safe and happy in our program, please tell us if they have any **diagnosed health, dietary or behavioral concerns** that we should be aware of. You may choose to speak with a Director if you prefer.

• IMMUNIZATION RECORD REQUIRED •

As required by State of Maine Child Care Licensing rules, your child cannot begin in our program until we receive a copy of their current immunization record (from birth to present). Please email their record along with this registration form.

Please list all medications your child is currently taking:

Please check here if your child is prescribed the following: ☐ **Epi-Pen** ☐ **Emergency Inhaler**

*You are responsible for providing P.A.L. with an **unexpired Epi-Pen and/or Emergency Inhaler** to be kept on site. If you checked yes to either or both boxes you must have the **Allergy/Anaphylaxis Action Plan** and /or **Asthma Action Plan** forms completed by your child's healthcare provider prior to your child attending P.A.L.*

Healthcare Provider: **Phone Number(s):**

Physical Address: _____ _____ _____
(Street) *(City / State)* *(Zip Code)*

Dentist: **Phone Number(s):**

Physical Address: _____ _____ _____
(Street) *(City / State)* *(Zip Code)*

Additional Information

We at P.A.L. believe that good communication between families and staff is the best way to provide quality care and a happy, healthy environment for all the children in our program. Please use this section to tell us about your child and/or your family that may help us in that endeavor. For example; what are their likes or dislikes, interests or hobbies? Do you have a special way of calming your child if they become upset? Anything you wish to share will be helpful.

•If your child has an **IFSP (Individualized Family Service Plan), IEP (Individualized Education Plan) or a 504 Plan** you may choose to note it here and/or you may speak with a Director.

2026-2027 • Parent/Guardian Agreement Checklist

Medical Release

I hereby give my permission for the P.A.L. Program staff to give my child _____, simple first aid when necessary. In the event of serious injury, I authorize ambulance or squad attendants to administer such treatment as is medically necessary; and I authorize the hospital to undertake examination and treatment if warranted on behalf of my child.

Printed Name: _____ **Signature:** _____

Immunization Record

I understand that I am required to include a copy of my child's current immunization record with this form. I also understand that as required by State of Maine Child Care Licensing rules, my child cannot begin in the program until I have done so.

Initials: _____

Payment Policy

I have read and agree to comply with the payment policy as outlined in the Parent Handbook. I, **as the contracted parent**, agree to pay 100% of all tuition charges, all fees (including Non-Sufficient Funds Fee) and all fundraiser obligations.

Initials: _____

Tuition Express Form and Registration Fees

I agree to providing a valid credit/debit card OR bank account information on the Tuition Express Form attached. I agree that Tuition payments will be **automatically** charged weekly to my account on file for the following week's tuition. Once I receive email confirmation that my child's spot is confirmed, I understand that the Registration fee & Tuition Security Deposit will be automatically charged to my account on file within two weeks.

Initials: _____

Late Pick Up Policy

I agree to comply with the late pick-up policy. I understand that PAL closes at 6:00pm. If I am late picking up my child according to the clock at the sign out desk, I will be charged a $5.00 per minute late fee (fee doubles for 2nd late occurrence).

Initials: _____

"No Call" Fee Policy

I have read and agree to comply with the "No Call" fee policy as outlined in the Parent Handbook. I understand that it is my responsibility to notify the Program before 1:45 pm of a schedule change taking place on that day. I must call 207-363-1441 to make this notification, **emails are not acceptable**. If I fail to call the Program, I am responsible for a $10.00 No Call Fee.

Initials: _____

Fundraiser Policy

I have read and agree to comply with the Fundraiser Policy as outlined in the Parent Handbook. I understand that I am responsible for raising $200.00 per school year, either through participation in various fundraisers or by direct donation. If I fail to meet this obligation in full, I will be charged for the remaining amount.

Initials: _____

Photography Consent/Release

I give permission for the P.A.L. Program to use photographs and video of my child for promotion or use on our social media sites. I authorize the use without receipt of compensation and release the Program from liability of this usage.

Please Initial One: **Accept** _____ **Decline** _____

Orientation Conference

☐ I would like to meet with a Director to better orient myself with the program and to discuss policies and procedures before my child begins. I would like a Director to call/email me to arrange a conference.

☐ I do not wish to meet for an orientation conference to discuss policies and procedures before my child begins.
(If you check this box, please know that you may request a conference with a Director at a later date/time if you choose)

By signing below, I acknowledge that I have read and agree to comply with the P.A.L. Program's Policies and Procedures listed in the Parent Handbook.

_____ _____ _____

(Printed Name) ***(Signature)*** ***(Date)***

2026-2027 • Scheduling Form

Child's Name: _____

DATE child will begin at P.A.L. _____
Month & Day

WEEKLY SCHEDULING

A spot will be held for your child to attend the program Monday through Friday every week. You can choose morning sessions, afternoon sessions, or both. If you choose not to send your child 5 days, please indicate below which days they will be attending each week. You will be charged the full weekly tuition for mornings and/or afternoons whether your child attends or not, as this will always guarantee space for your child on those days.

We MUST be notified if they will not be attending the program for the day / need to be added to an additional day*

Circle the session/days your child will be attending each week:
**If you're unsure which days - or if it changes weekly, you will need to call PAL daily/weekly to let us know!*

MORNINGS: M T W Th F

VES/CRES/Middle
Weekly A.M. Tuition $100

AFTERNOONS: M T W Th F

VES/CRES/Middle
Weekly P.M. Tuition $175

My TOTAL Weekly Tuition = $_____

The discount for using your Checking/Savings account will be reflected in your weekly charges

Tuition will be automatically charged weekly to your account on file for the following week's tuition.
~PLEASE REFER TO BILLING SECTION IN HANDBOOK FOR MORE DETAILS~

OFFICE USE ONLY

Staff Notes:

***Registration Fee** $100 first child *($50 after March 1st of current school year)* & $20 each additional child **AND Refundable Tuition Security Deposit** $100, will be charged to their account within 2 weeks once spot is confirmed.

☐ **Complete Registration** ☐ **Tuition Express** ☐ **Immunization Record** ☐ **MS Walking Form**

Staff Receiving Form: *Date Received:* *Confirmed 'Spot' on:*

Automated Payment Processing
Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express® – a payment processing system that allows on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) _____ ☐ **to initiate credit card charges to the below referenced credit card account (Section A) OR,** ☐ **initiate debit entries to my (our) Checking or Savings Account, indicated below (Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit Union Members: Please contact your Credit Union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

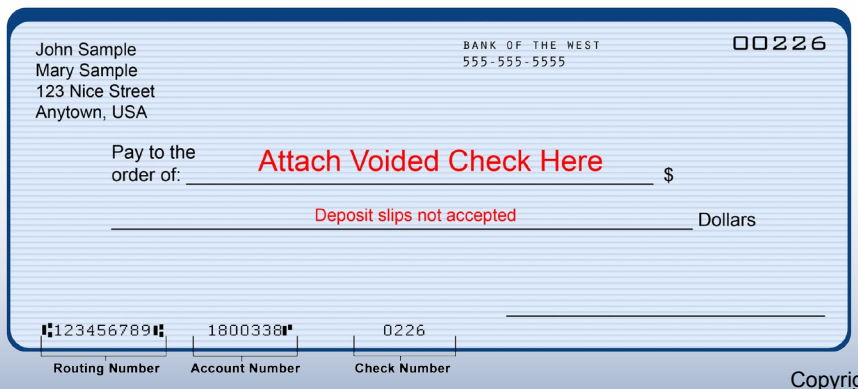
Bank or Credit Union Name _____

Bank or Credit Union Address _____ City _____ State _____ Zip _____ ☐ Checking ☐ Savings

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____

For Official Use Only

Date Received
Employee Signature



A service of

procare SOFTWARE®

Dear parent/guardian,

PAL is pleased to offer **MyProcare**, a free online portal for you to access account information, end-of-year tax documents and easily update payment information. MyProcare is safe, secure and created with your convenience in mind.

Log in today!

1. Go to MyProcare.com.

2. Enter your email address (the email you have on file with PAL) and choose ***Secure Login***.

3. Enter the confirmation code sent to your email, choose a password, and press ***Submit***.

4. Then you may:

    a. View your child's schedule, account information and more.

    b. View End-of-Year Tax documents

Thank you!

PAL and MyProcare

2026/2027 MIDDLE SCHOOL STUDENTS
attending the P.A.L. Program:

- -

RELEASE OF LIABILITY FORM

I, _____, am the Parent/Guardian of _____,
Parent/Guardian name *child's full name*

and I give permission for this child to walk independently to/from the P.A.L. Program before and/or after school.

I understand the school bus company will NOT be transporting the Middle School Students to or from the P.A.L. Program. My student will be walking independently from the P.A.L. Program to Middle School in the morning or from Middle School to the P.A.L. Program in the afternoon.

I do assume the risk in my child's participation in this event. I acknowledge that I will not seek to have Parents Alternative to Latchkey (the P.A.L. Program) held liable in any adverse events including but not limited to the following: accidents, injury, loss of property to the child or children, or damage to other individuals or their property.

I hereby release and agree to hold harmless the P.A.L. Program and its employees from any claims arising out of my child walking independently to and or from the P.A.L. Program.

MIDDLE SCHOOL AFTERNOON SESSION: I understand that the afternoon Middle School Session is subject to cancellation if enrollment numbers drop below a level that is financially sustainable to operate. In the event that the Middle School session must be discontinued, a two-week notice will be provided to me.

I have read, understand and accept all of the statements recited above and accept full responsibility as described.

_____ _____
Parent/Guardian Signature Date Signed

_____ _____
PAL Staff Initials Date Form Received

ALLERGY/ANAPHYLAXIS ACTION PLAN

Student Photo

Student Name _____ **D.O.B.** _____ **Teacher** _____

School Nurse_____ **Phone Number** _____
Health Care Provider _____ **Preferred Hospital** _____

History of Asthma No Yes-Higher risk for severe reaction

ALLERGY: (check appropriate) **To be completed by Health Care Provider**

- ☐ **Foods (list):**
- ☐ **Medications (list):**
- ☐ **Latex: Circle: Type I (anaphylaxis) Type IV (contact dermatitis)**
- ☐ **Stinging Insects (list):**

RECOGNITION AND TREATMENT

Chart to be completed by Health Care Provider ONLY		**Give CHECKED Medication**	
If food ingested or contact w/ allergen occurs:		Epinephrine	Antihistamine
No symptoms noted	☐ Observe for other 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 BP, fainting, pale, blueness		
Neuro+	Disorientation, dizziness, loss of consciousness		
If reaction is progressing (several of the above areas affected), GIVE:			
The severity of symptoms can quickly change. +Potentially life-threatening.			

DOSAGE:

Epinephrine: Inject into outer thigh ☐ **0.3 mg** OR ☐ **0.15 mg**
Antihistamine: Liquid Diphenhydramine (Benadryl®) _____ml. To be given by mouth *only if able to swallow.*
Other:

☐ This child has received instruction in the proper use of the Auto-injector: EpiPen® or Twinject® (circle one). It is my professional opinion that this student **SHOULD** be allowed to carry and use the auto-injector independently. The child knows when to request antihistamine and has been advised to inform a responsible adult if the auto-injector is self-administered.
☐ It is my professional opinion that this student **SHOULD NOT** carry an auto-injector.

Health Care Provider Signature _____ Phone: _____ Date _____

EMERGENCY CALLS

1. **Call 911**. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call parents/guardian to notify of reaction, treatment and student's health status.
3. Treat for shock. Prepare to do CPR.
4. Accompany student to ER if no parent/guardians are available.

Rev. 7/06

This form is adapted from The Food Allergy Anaphylaxis Network, "Food Allergy Action Plan" & the Asthma and Allergy Foundation of America, AK Chapter

Side 2: To Be Completed by Parent/Guardian, Student and School

Allergy/Anaphylaxis Action Plan *(continued)* **Student Name** _____ **D.O.B.** _____

Each school will have 2 auto-injectors and liquid Diphenhydramine (Benadryl®) available during regular school hours. If your child participates in before or after school activities, your child will need to have an auto-injector on their person.

Parent/Guardian AUTHORIZATIONS

- ☐ I want this allergy plan implemented for my child; **I want my child to carry an auto-injector** and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of an auto-injector.
- ☐ I want this plan implemented for my child and I **do not** want my child to self-administer epinephrine.

Your signature gives permission for the nurse to contact and receive additional information from your health care provider regarding the allergic condition(s) and the prescribed medication.

Parent/Guardian Signature: _____ Phone:_____ Date:_____

Student Agreement:

- ☐ I have been trained in the use of my auto-injector and allergy medication and understand the signs and symptoms for which they are given;
- ☐ I agree to carry my auto-injector with me at all times;
- ☐ I will notify a responsible adult (teacher, nurse, coach, noon duty, etc.) **IMMEDIATELY** when my auto-injector (epinephrine) is used;
- ☐ I will not share my medication with other students or leave my auto-injector unattended;
- ☐ I will not use my allergy medications for any other use than what it is prescribed for.

Student Signature: _____ **Date** _____

Approved by Nurse/Principal Signature: _____ **Date** _____

PREVENTION: Avoidance of allergen is crucial to prevent anaphylaxis.

Critical components to prevent life threatening reactions: ☑ Indicates activity completed by school staff

	Encourage the use of Medic-alert bracelets
	Notify nurse, teacher(s), front office and kitchen staff of known allergies
	Use non-latex gloves and eliminate powdered latex gloves in schools
	Ask parents to provide non-latex personal supplies for latex allergic students
	Post "Latex reduced environment" sign at entrance of building
	Encourage a no-peanut zone in the school cafeteria
	Other:

STAFF MEMBERS TRAINED

Name	Title	Location/Room #	Trained By

EMERGENCY CONTACTS

	Name	Home #	Work #	Cell #
Parent/Guardian				
Parent/Guardian				
Other:				
Other:				

This form is adapted from The Food Allergy Anaphylaxis Network, "Food Allergy Action Plan" & the Asthma and Allergy Foundation of America, AK Chapter

Rev. 7/06

Asthma Action Plan for: _____ Grade: _____

Date of Birth: _____ Personal Best Peak Flow: _____ Date: _____

For School Age Children K-12

WHAT TO DO WHEN YOU HAVE SYMPTOMS

GREEN ZONE

GOOD!

Look For These Signs

- No cough, wheeze, or difficulty breathing
- Can sleep through the night
- Can do regular activities

What You Should Do

- Take your **DAILY CONTROLLER MEDICINES**
- Exercise regularly
- Medicine to take before exercise: _____
- Avoid your triggers:
  Tobacco smoke
  _____
  _____
- Notes: _____
  _____

PEAK FLOW _____ — _____

YELLOW ZONE

CAUTION!

Look For These Signs

- Cough, wheeze, short of breath
- Waking at night due to wheeze or cough more than 2 times a month
- Can't do regular activities
- Using quick relief medicine more than 2 times a week (not counting use before exercise)

What You Should Do

- Keep taking your daily controller medicine
- Begin using **QUICK RELIEF MEDICINE** every 4-6 hours as prescribed (Prime it first, if needed)
- Notes: _____
  _____
- If not better in 24-48 hours, call your doctor or nurse!
- If at school, call parent

PEAK FLOW _____ — _____

RED ZONE

DANGER!

Look For These Signs

- Very short of breath
- Hard time walking or talking
- Skin around neck or between ribs pulls in
- Quick relief medicine not helping

What You Should Do

- Get help now
- Take a nebulizer treatment
  OR
  Take 4 puffs of quick relief medicine now

CALL YOUR DOCTOR OR NURSE NOW!

OR

Go to the Emergency Room or Call 911

PEAK FLOW less than _____

MEDICINES

Classification: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

DAILY CONTROLLER MEDICINE	HOW MUCH	HOW OFTEN	
☐ Pulmicort Respules			____times/day
☐ Pulmicort Flexhaler		____puffs	____times/day
☐ Flovent		____puffs	____times/day
☐ Singulair			At bedtime
☐ Asmanex		____puffs	At bedtime
☐ Symbicort		2 puffs	2 times/day
☐ Advair		____puffs	2 times/day

☐ Other _____ ☐ **Use Spacer**

QUICK RELIEF MEDICINE

☐ Inhaler ☐ Nebulizer
Med:
Dose:
Frequency:

☐ Inhaler ☐ Nebulizer
Med:
Dose:
Frequency:

REMINDER: GET A FLU SHOT

SIGNATURES

School: _____ **Phone:** _____ **Fax:** _____

This child may carry his/her: Inhaled Asthma Medicine ☐ Yes ☐ No Epi-Pen ☐ Yes ☐ No ☐ N/A

Parent Authorizes the exchange of information about this child's asthma between the physician's office and the school nurse: ☐ Yes ☐ No

Maine law permits students to carry and use inhaled medicines and epi-pen **after** demonstrating appropriate use to the school nurse.

Please call the healthcare provider and the parent if the child is using quick relief inhaler more than 2 x per week (i.e. in excess of pre-exercise treatment)

Healthcare Provider Signature _____ **Phone** _____

School Nurse Signature _____

Parent Signature _____ **Phone** _____

Form revised 06/10
Maine Asthma Council

Physicians: Fax completed copy to school nurse

Parents: Keep this handy