asap184 ARTS AND SCIENCE APPRECIATION PROGRAM

# CHILDCARE REGISTRATION FORM

## CHILD'S INFORMATION

| FIRST NAME | MIDDLE | LAST NAME | DATE OF BIRTH |
|---|---|---|---|
| | | | |

| NAME PREFERRED TO USE | CLASS | TEACHER'S NAME |
|---|---|---|
| | | |

| STREET ADDRESS | TOWN/CITY | ZIP CODE |
|---|---|---|
| | | |

## PARENT/GUARDIAN INFORMATION 1

| FIRST NAME | MIDDLE | LAST NAME | HOME PHONE# |
|---|---|---|---|
| STREET ADDRESS | TOWN/CITY | ZIP CODE | MOBILE PHONE# |
| ADDRESS WHERE YOU CAN BE REACHED WHILE CHILD IS IN CARE | TOWN/CITY | ZIP CODE | WORK PHONE# |
| PERSON RESPONSIBLE FOR PAYMENT: FIRST NAME | MIDDLE | LAST NAME | PRIMARY EMAIL ADDRESS |

## PARENT/GUARDIAN INFORMATION 2

| FIRST NAME | MIDDLE | LAST NAME | HOME PHONE# |
|---|---|---|---|
| STREET ADDRESS | TOWN/CITY | ZIP CODE | MOBILE PHONE# |
| ADDRESS WHERE YOU CAN BE REACHED WHILE CHILD IS IN CARE | TOWN/CITY | ZIP CODE | WORK PHONE# |

## OTHER PEOPLE TO NOTIFY IN CASE OF EMERGENCY 1

| FIRST NAME: | ADDRESS | HOME PHONE# |
|---|---|---|
| RELATIONSHIP: | | MOBIL PHONE# |
| PERMISSION TO PICK UP IN EMERGENCY? ☐ NO ☐ YES | | WORK PHONE# |

## OTHER PEOPLE TO NOTIFY IN CASE OF EMERGENCY 2

| FIRST NAME: | ADDRESS | HOME PHONE# |
|---|---|---|
| RELATIONSHIP: | | MOBIL PHONE# |
| PERMISSION TO PICK UP IN EMERGENCY? ☐ NO ☐ YES | | WORK PHONE# |

PLEASE INDICATE IF YOUR CHILD ATTENDS "EXTENDED DAY" (TUESDAY/THURSDAY)? ☐ YES ☐ NO

# CONTRACT

This contract is an agreement between: ________________________ (parent/guardian)

and Arts & Science Appreciation Program (ASAP).

To provide care for: ________________________ (child's name)

This contract will be in effect from ____________ to JUNE 2016

It is understood that this contract is based on the ten-month school year schedule. This contract expires at the end of June, i.e. the end of the current school calendar year.

INITIALS

## 2015-2016 CHILDCARE PROGRAM PRICE LIST

| | | | | | | |
|---|---|---|---|---|---|---|
| Registration Fee per Participant | $30 * | *Non-refundable | | | | |
| Insurance Fee per Participant | $35 ** | **Non-refundable | | | | |
| 5 days/week (Dismissal to 6:00pm) | $430 monthly | | | | | |
| 4 days/week (Dismissal to 6:00pm) | $370 monthly | M | T | W | Th | F |
| 3 days/week (Dismissal to 6:00pm) | $299 monthly | M | T | W | Th | F |
| 2 days/week (Dismissal to 6:00pm) | $214 monthly | M | T | W | Th | F |
| Pre-Kindergarten Participants (2:10pm Dismissal to 6:00pm) | $35 monthly added to base fee | | | | | |
| Early Dismissal (11:25am to 2:30pm) | $30 per day | | | | | |
| Emergency Care (Dismissal to 6:00pm) | $30 per day | Child must be registered | | | | |

There will be a two week trial period in which either party may end this agreement, for any reason. Any fees paid will not be refunded should this occur. This does not apply to yearly renewal contracts. (Payments are **due on the 1st of the month** for the following month, according to schedule.)

INITIALS

This contract is simple and agreed upon.

INITIALS

| PRINT PARENT/GUARDIAN NAME | SIGNATURE | DATE |
|---|---|---|
| | | |

| PRINT PARENT/GUARDIAN NAME | SIGNATURE | DATE |
|---|---|---|
| | | |

# CHILD PICK-UP FORM

The following people HAVE permission to pick-up the child named below from the care of ASAP.
It is the parent's responsibility to notify ASAP in writing of any changes.

## CHILD IN CARE

| NAME | CLASS | SEX | DATE OF BIRTH | | |
|---|---|---|---|---|---|
| | | | | | |

## PERSON PERMITTED TO PICK-UP CHILD 1

| NAME | RELATION |
|---|---|
| | |

| ADDRESS | PHONE # |
|---|---|
| | |

## PERSON PERMITTED TO PICK-UP CHILD 2

| NAME | RELATION |
|---|---|
| | |

| ADDRESS | PHONE # |
|---|---|
| | |

## PERSON PERMITTED TO PICK-UP CHILD 3

| NAME | RELATION |
|---|---|
| | |

| ADDRESS | PHONE # |
|---|---|
| | |

The following people DO NOT have permission to pick-up the child named from ASAP

## PERSON **NOT** PERMITTED TO PICK-UP CHILD 1

| NAME | RELATION |
|---|---|
| | |

| ADDRESS | PHONE # |
|---|---|
| | |

## PERSON **NOT** PERMITTED TO PICK-UP CHILD 2

| NAME | RELATION |
|---|---|
| | |

| ADDRESS | PHONE # |
|---|---|
| | |

NOTE: Any person unfamiliar to ASAP will be required to show proof of identification. Under NO circumstances will the child be released to anyone other than those listed above without advanced permission from the parent.
This form is legally binding, so by signing it, you agree that all of the information provided herein is correct.
False Information will result in termination of contract, and you will forfeit your childcare retainer.

| PRINT PARENT/GUARDIAN NAME | SIGNATURE | DATE |
|---|---|---|
| | | |

| PRINT PARENT/GUARDIAN NAME | SIGNATURE | DATE |
|---|---|---|
| | | |

## CHILD'S HEALTH INFORMATION

| DATE OF LAST PHYSICAL EXAM | HEALTH CARE PROVIDER | PHONE # |
|---|---|---|
| | | |

| STREET ADDRESS | TOWN/CITY | ZIP CODE |
|---|---|---|
| | | |

| SPECIAL HEALTH PROBLEMS?<br>☐ NO IF ☐ YES SPECIFY | ALLERGIES INCLUDING DRUG REACTIONS?<br>☐ NO IF ☐ YES SPECIFY |
|---|---|
| **REGULAR MEDICATIONS?**<br>☐ NO IF ☐ YES SPECIFY | **OTHER IMPORTANT INFORMATION** |
| CHILD'S DENTIST NAME | PHONE # |

| STREET ADDRESS | TOWN/CITY | ZIP CODE |
|---|---|---|
| | | |

## CHILD'S INSURANCE INFORMATION 1

| INSURANCE COMPANY NAME | MEMBER/POLICY NUMBER |
|---|---|
| POLICY HOLDER NAME | EMPLOYER NAME |

## CHILD'S INSURANCE INFORMATION 2

| INSURANCE COMPANY NAME | MEMBER/POLICY NUMBER |
|---|---|
| POLICY HOLDER NAME | EMPLOYER NAME |

## CONSENT TO MEDICAL CARE & TREATMENT OF A MINOR

I give permission that my child, ___________________________ , may be given first aid/emergency treatment by a qualified child care provider and/or staff at ASAP at P.S. 184 Flushing Manor, 163-15 21 Road, Whitestone, NY11357 When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician or aid car attendant to safeguard my child's health.

I waive my right of informed consent to such treatment.

I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

I certify under penalty of perjury under the laws of the State of New York that this information is true and correct.

| PRINT PARENT/GUARDIAN NAME | SIGNATURE | DATE |
|---|---|---|
| | | |

| PRINT PARENT/GUARDIAN NAME | SIGNATURE | DATE |
|---|---|---|
| | | |

# MEDICAL/HEALTH AGREEMENT FORM

DUE DATE: INITIALS:

Procedure: Parent/guardian is to have the child's physician complete the DOHMH Health Examination form CH-205 and return the form to ASAP by the date listed above.

It is imperative that a current health form (DOHMH CH-205) be on file before any child begins care at our facility. Failure to do so will mean that the provider cannot accept your child until the form is appropriately completed.

I _________________________ (parent/guardian) grant permission to ASAP and P.S. 184 to access my child's (child's name _________________________) present medical records that are on file at P.S. 184. This medical form copy is current and accurate. In addition, the parent/guardian will update the medical information (following scheduled check ups, immunizations, allergies, etc) as needed with ASAP. I have read this statement and agree to its terms.

INITIALS

| PRINT PARENT/GUARDIAN NAME | SIGNATURE | DATE |
|---|---|---|
| PRINT PARENT/GUARDIAN NAME | SIGNATURE | DATE |
| ASAP PRINT NAME | SIGNATURE | DATE |

# WAIVER

I hereby grant permission for my child to supervised by the ASAP PROGRAM for activities, including field trips. I understand that notice of all activities will be posted prior to any trip. In case of medical emergency, I understand that every effort will be made to contact me or my emergency contact. If I or someone on the emergency form cannot be reached, I give the ASAP Program permission to secure the medical treatment necessary for my child; including hospitalization, injection, anesthesia or surgery.

I understand that the ASAP Program assumes no responsibility for injuries or illnesses which my child sustain as a result of his/her physical condition or resulting from his/her participation in any athletic activities, sports program, the use of any equipment, exercise or other activities. I expressly acknowledge on behalf of myself and my heirs that I assume the risk for any and all injuries and illness which may result from his/her participation in these activities and I hereby release and discharge the ASAP Program, its agents, servants, and employees from any and all claims for injury, illness, death, loss or damage which he/she may suffer as a result of his/her participation in these activities.

I understand that the ASAP Program is not responsible for personal property lost or stolen while members and/or program participants are using ASAP facilities or on ASAP Program premises. This disclaimer also extends to the facilities used in the commission of the child care program. I give permission to the ASAP Program to use, without limitation or obligation, photographs, film footage, my child's image or voice for purpose of promoting or interpreting ASAP Programs.

I acknowledge the Waiver and accept the conditions set forth above and, an in sympathy with the Goals and purposes of the ASAP Program. I agree to adhere and abide by the policies.

| PRINT PARENT/GUARDIAN NAME | SIGNATURE | DATE |
| --- | --- | --- |
| | | |

ASAP 184 ARTS AND SCIENCE APPRECIATION PROGRAM

# PHOTO IDENTIFICATION RELEASE FORM

## CHILD IN CARE

| NAME | CLASS | SEX | DATE OF BIRTH | | |
|---|---|---|---|---|---|
| | | | | | |

The ASAP reserves the rights to photograph your child(s) for identification, filing and media purposes.

INITIALS

I hereby consent to the participation in interviews, the use of quotes, and taking of photographs, movies or video tapes of the student named above. I also grant to ASAP the right to edit, use, and reuse said products for non-profit purposes including use in print, on the internet, and all other forms of media. I also hereby release ASAP and its agents and employees from all claims, demands, and liabilities whatsoever in connection with the above.

INITIALS

This contract is simple as all rules are agreed upon and followed as part of this contract.

INITIALS

| PRINT PARENT/GUARDIAN NAME | SIGNATURE | DATE |
|---|---|---|
| | | |

| PRINT PARENT/GUARDIAN NAME | SIGNATURE | DATE |
|---|---|---|
| | | |