AFTER SCHOOL PROGRAM ENROLLMENT FORM

(JR KINDERGARTEN– 4TH GRADE)

CHILD'S NAME:____ **GRADE** (2020/2021) ___________

BIRTHDATE: ______ /______/______ **AGE:**____ **SEX:** M F **TEACHER:**______________________ **T-SHIRT SIZE**_____
(Only if sponsored)

Please check below which plan you are choosing: **PROGRAM LIMIT**: 35

FULL TIME:______ **HOURLY**______ **DAYS ATTENDING:** M T W R F (please circle)

***REGISTRATION FEES: DEPOSIT PAID:**__________________ **AMOUNT PAID:**_____________**IMMUNIZATION**_______

_______ ***DEPOSIT PER FAMILY:** $50.00 **(CASH/MONEY ORDER OR DEBIT/CREDIT CARD ACCEPTED ONLY)**
Checks will not be accepted for Deposit **- (WILL BE RETURNED AFTER FINAL FEES ARE PAID IN FULL OR USE IT FOR LAST MONTH)**

_______ ***FULL TIME:** *$100.00 PER MONTH– 2ND CHILD: $85.00 PER MONTH
DUE AT REGISTRATION & LAST FRIDAY OF EACH MONTH
Teacher Inservice/Early Out Days: Included in Monthly Plan

_______ **HOURLY:** $4.00 PER HOUR PER CHILD - ***Billed at End of Month-Due by 10th of Next Month**
1st Hourly Rate will be charged from beginning of program until 4:45 p.m. **1.5 Hrs = $6.00**

_______ ***EARLY OUT - TEACHER INSERVICE DAYS:** **½ DAY**: $15.00 **FULL DAY:** $25.00
* (Student Must be enrolled in Program)

$5 LATE FEE WILL BE CHARGED AFTER DEADLINES) - CREDITS FOR MISSED DAYS WILL ONLY BE GIVEN DUE TO SICKNESS

PROGRAM LIMIT: 35 **TRANSPORTATION FEE** for field trips/events will be charged accordingly throughout program!

PARENT OR GUARDIAN WITH WHOM CHILD RESIDES:

NAME (Print) ____ PHONE: (H)____________ W)____________

ADDRESS____ CELL______________________

E-MAIL ADDRESS____

PERSON RESPONSIBLE FOR PAYMENT, IF DIFFERENT FROM ABOVE:

NAME (Print)____ PHONE: (H)____________ (W)____________

ADDRESS____ CELL ________________________

PERSONS AUTHORIZED TO PICKUP YOUR CHILD: ***(Any changes from this list must be received from you in writing)***

1.NAME (Print)____ PHONE_______________________

2.NAME (Print)____ PHONE_______________________

3.NAME (Print)____ PHONE_______________________

EMERGENCY PHONE NUMBERS:

1. NAME (Print)____ PHONE_____________________

2. NAME (Print)____ PHONE____________________

3. NAME (Print)____ PHONE____________________

****PLEASE INFORM STAFF OF ANY SPECIAL NEEDS OR CHANGES IN PROCEDURES****

SPECIAL NEEDS INFORMATION *(If applicable)***Parents - Special Needs Children** who require **one-on-one help at PAS School will also be required to have one-on-one help** at **all times** during the After School Program.

Special Needs Yes____ No____ One-on-One Yes____ No____

List any special circumstances or needs that may apply to your child:____

____

CHILDREN'S PHYSICIAN:

NAME: (Print) ____ PHONE:______________

My child is allergic to the following medications and anesthetics:____

Please list below any medical conditions we should be aware of: ____

____

WATER BOTTLES: Each child is responsible to bring a water bottle labeled with their name.

HEALTH SCREENING INFORMATION

Staff will sign your child out each day.
Call 215-0829 and let staff know you are there to pick them up.
Staff will bring your child out to you.

Hand Washing-Sanitizing will be practiced throughout the program.

PARENTS – YOU ARE RESPONSIBLE for bringing your child to other programs!

MEDICATION POLICY: Parent/Guardians -**YOU ARE RESPONSIBLE** for administering medications to your child during this program. Medications **WILL NOT BE ADMINISTERED** by After School Program staff!

IMMUNIZATION POLICY: A copy of your child's immunization information is required prior to beginning of program.

WAIVER: I, the UNDERSIGNED, parent or guardian do hereby agree to **allow my child to participate** in the After School Program, and further agree to indemnify and hold the City of Pipestone, Ind. School District #2689 or the Pipestone County Extension organization harmless from and against any and all liability for any injury which may be suffered by my son/daughter arising out of or in any way connected with his/her participation in this activity.

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I hereby authorize emergency medical care for my child during attendance at the After School Program if, in the judgment of the staff, treatment is required for any injury or illness. I hereby also authorize the administering of anesthetics and recourse to other procedures deemed necessary by the attending physician. I understand that I am financially responsible for any expenses for medical care or transportation incurred on my child's behalf and that whenever possible, I will be notified prior to medical treatment of my child or at the earliest possible time should prior notice prove impossible.

AUTHORIZATION FOR PROGRAM ADVERTISEMENT/PHOTOS

I authorize that photos during the program may be taken of my child and used for advertisement for the After School Program and United Way either/or on the City/School District or United Way website or for the community newspaper.

Please check here if you **do not want** your child photographed during this program_____________

AUTHORIZATION FOR FIELD TRIPS

I authorize that my child may participate in any special events or field trips that are sponsored by this program. If I do not want my child to participate in an event or trip, I will personally inform the After School Program Coordinator and the Pipestone Recreation Department in advance! I also authorize my child to ride the school bus , the County taxi and ride bike to and from the program. (if applicable)

Please check here if you **do not give your child permission** to do the above_____________

AUTHORIZATION FOR PIPESTONE COUNTY EXTENSION OFFICE

Because we offer monthly 4-H programs at the After School Activity Center, your child will also be enrolled as a Clover Buddy and will be considered a Pipestone County 4-H member. Your child's name, address, phone number, gender, birth date, grade and school will be shared with the Pipestone County Extension Office.

Please check here if you **are not interested** in sharing this information______________

Child's Name____ **AGE**_____ **BIRTH DATE**_______________

PARENT'S NAME (Print)____

____**DATE**________________

SIGNATURE OF PARENT