



# City of Bluefield Parks and Recreation After-School Program

## Enrollment Agreement

Completion of this agreement is required for enrollment. This form will enable us to better understand your child and meet his/her needs. Much of the information requested is necessary to comply with state child care licensing regulations.

### Enrollment Information

#### Child's Information

Child's first name		Child's middle name		Child's last name		Child's nickname		
Age	Sex	Child's primary language			Parent/guardian/sponsor primary language			
Child's home address				City		State		Zip
School name		School address			Grade		School phone	

#### Family Information

Parent/Guardian		Relationship to child		Home phone		Cell phone			
Home address if different from above				City		State		Zip	
Email						Work phone			
Employer		Employer address		City		State		Zip	Work hours
<b>Other</b> Parent/Guardian		Relationship to child		Home phone		Cell phone			
Home address if different from above				City		State		Zip	
Email						Work phone			
Employer		Employer address		City		State		Zip	Work hours

#### Child Emergency Contact and Release Information *(do not include parents/guardians)*

Please notify the center if an Emergency Release Contact will pick up your child on a given day.

<b>Person #1</b>		Relationship to child		Home phone		Cell phone		
Home address				City		State		Zip
<b>Person #2</b>		Relationship to child		Home phone		Cell phone		
Home address				City		State		Zip
<b>Person #3</b>		Relationship to child		Home phone		Cell phone		
Home address				City		State		Zip

#### Authorized Pick-Up Persons *(if separate from Emergency Contacts)*

[For the safety of your child, we request that all authorized pick up persons with whom staff is not familiar provide a photo ID at the time of pick-up.]

Name	Address	Phone Number
Name	Address	Phone Number
Name	Address	Phone Number

The persons designated in the Emergency Contact and Release section will be contacted by us if you cannot be reached in the event of a medical or other emergency. Our staff will only release your child to you or to those persons listed above. If you want a person who is not identified above to pick up your child, you must notify our staff in advance, in writing. Your child will not be released without prior authorization.

#### Special Pick-Up Instructions

[Biological/custodial parents must be given access to their children, unless there is a court order preventing it. A copy of the court order will be placed on file.]

Any individuals with court orders against them, therefore, preventing child pick-up may be listed below.

Name	Relationship to Child
Name	Relationship to Child

Other Restrictions on Child Pick-Up:

Parent initial \_\_\_\_\_ Staff initial \_\_\_\_\_ Date \_\_\_\_\_

## Medical Information

Child's name	Birth date	Height	Weight	Hair color	Eye color
--------------	------------	--------	--------	------------	-----------

Distinguishing marks \_\_\_\_\_

### Child's Medical & Developmental History

1. Does your child have any special medical conditions?  No  Yes Explain \_\_\_\_\_
2. Does your child have any chronic illnesses?  No  Yes Explain \_\_\_\_\_
3. Please list a brief history of your child's serious injuries and hospitalizations. \_\_\_\_\_
4. Does your child have diabetes?  No  Yes *If yes, please attach care instructions from your physician.*
5. Does your child have asthma?  No  Yes *If yes, please attach care instructions from your physician.*
6. Will medication need to be administered regularly?  No  Yes *If yes, personal arrangements will need to be made. Our staff will not be certified to administer medicine.*
7. Does your child have any special dietary needs?  No  Yes Explain \_\_\_\_\_
8. Is your child able to fully participate in all activities?  Yes  No Explain \_\_\_\_\_
9. Does your child have any physical restrictions?  No  Yes Explain \_\_\_\_\_
10. Does your child function at the level of other children in his/her age group?  Yes  No Explain \_\_\_\_\_
11. Is your child able to walk  Yes  No
12. Can your child communicate his/her needs?  Yes  No
13. Does your child need assistance at meal time?  No  Yes Explain \_\_\_\_\_
14. Does your child rest during the day?  No  Yes
15. Is your child toilet trained?  No  Yes
16. Does your child use any special equipment, such as breathing machine, wheelchair, hearing aid, braces, glasses, etc.?  No  Yes Explain \_\_\_\_\_
17. Does your child require one-to-one care/supervision on a regular basis for a significant period of time?  No  Yes Explain \_\_\_\_\_
18. Does your child require any accommodations or modifications to fully and equally enjoy and participated in a group care setting?  
 No  Yes Explain \_\_\_\_\_

#### Illness History *(please check all that apply)*

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Vision problems           | <input type="checkbox"/> Nosebleeds               | <input type="checkbox"/> Seizures         |
| <input type="checkbox"/> Hearing problems          | <input type="checkbox"/> Skin rashes              | <input type="checkbox"/> Mouth sores      |
| <input type="checkbox"/> Constipation              | <input type="checkbox"/> Sore throats             | <input type="checkbox"/> Fainting         |
| <input type="checkbox"/> Diarrhea                  | <input type="checkbox"/> Ear infections           | <input type="checkbox"/> Persistent cough |
| <input type="checkbox"/> Asthma/breathing problems | <input type="checkbox"/> Urinary tract infections | <input type="checkbox"/> Other            |

*Please attach care instructions from your physician for any of these illnesses.*

#### Disease History *(please check all that apply and add the date)*

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Chicken Pox (Varicella) _____  | <input type="checkbox"/> Bronchiolitis _____              | <input type="checkbox"/> Botulism _____                |
| <input type="checkbox"/> Measles Rubella _____          | <input type="checkbox"/> Pneumonia _____                  | <input type="checkbox"/> Haemophilus Influenza _____   |
| <input type="checkbox"/> Rubella (German Measles) _____ | <input type="checkbox"/> Pertussis (Whooping cough) _____ | <input type="checkbox"/> Meningococcal Infection _____ |
| <input type="checkbox"/> Mumps _____                    | <input type="checkbox"/> Tetanus _____                    | <input type="checkbox"/> Rabies _____                  |
| <input type="checkbox"/> Scarlet Fever _____            | <input type="checkbox"/> Diphtheria _____                 | <input type="checkbox"/> Bacterial Meningitis _____    |

#### Allergies *(please list)*

<b>Medication Allergies</b>	Reaction	<b>Food Allergies</b>	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
<b>Bee Stings Allergies</b>	Reaction	<b>Respiratory Allergies</b>	Reaction
_____	_____	_____	_____
<b>Other Allergies</b>	Reaction	<b>Are any of these allergies life-threatening?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
_____	_____		

*Please attach care instructions from your physician for any life-threatening allergies.*

#### Miscellaneous Screenings and Tests *(please check all that apply and add the date of last screening)*

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Vision _____  | <input type="checkbox"/> Developmental _____ | <input type="checkbox"/> Tuberculosis (PPD) _____ |
| <input type="checkbox"/> Hearing _____ | <input type="checkbox"/> Aptitude _____      | <input type="checkbox"/> Sickle Cell Anemia _____ |
| <input type="checkbox"/> Speech _____  | <input type="checkbox"/> Educational _____   | <input type="checkbox"/> Other _____              |

To the best of my knowledge the information contained above is accurate.

Parent initial \_\_\_\_\_ Staff initial \_\_\_\_\_ Date \_\_\_\_\_

## Medical Information (continued)

### Child's Medical Care Provider

Primary physician's name	Primary physician's practice name	Phone
Physician's practice address	City	State
Preferred hospital/clinic for emergency care	City	State

### Child's Insurance Provider

Child's health insurance provider name	Policy number	Secondary health insurance provider name	Policy number
--	---------------	--	---------------

### Child's Immunization History *(please attach a copy of your child's immunization records)*

Below is a list of immunizations that your child may have received. Immunizations in bold are required by our state.

Anthrax	Influenza	<b>Pneumococcal disease</b>	Smallpox
<b>Diphtheria</b>	Lyme Disease	<b>Polio</b>	<b>Tetanus</b>
<b>Haemophilus Influenzae type b (Hib)</b>	<b>Measles</b>	Rabies	Tuberculosis
<b>Hepatitis A</b>	Meningococcal disease	<b>Rotavirus</b>	Typhoid Fever
<b>Hepatitis B</b>	<b>Mumps</b>	<b>Rubella</b>	<b>Varicella (Chickenpox)</b>
Human Papillomavirus (HPV)	<b>Pertussis (Whooping Cough)</b>	Shingles (Herpes Zoster)	Yellow Fever

### Additional Medical Policies

1. Prior to enrollment, I must provide the center with updated medical and immunization information for my child. This information is to be kept current and updated in accordance with state child care regulations. **Initial**  
\_\_\_\_\_
2. I agree to provide information to the child care center about my child's conditions, illnesses, allergies or other needs. \_\_\_\_\_
3. If my child becomes ill with a reportable contagious disease, I understand that he/she will not be able to return until I bring in a physician's note stating that he/she is no longer contagious. \_\_\_\_\_
4. If my child becomes ill during his/her time at the child care center, the staff will contact me to pick up my child. I will arrange for pick up as soon as possible and no later than 2 hours after being contacted. If I cannot be reached, the staff will contact those listed in the *Child Emergency Contact and Release*. \_\_\_\_\_

### Emergency Medical Authorization & Consent

- In case of a medical emergency, the staff will attempt to contact me, those listed in the *Child Emergency Contact and Release*, and lastly my physician. **Initial**  
\_\_\_\_\_
- In case of a medical emergency, I agree that my child may receive first aid and/or CPR. \_\_\_\_\_
- In case of a medical emergency, I permit the transportation of my child to a local hospital or other urgent care facility, if necessary by paramedics or other emergency personnel. \_\_\_\_\_
- In case of a medical emergency, I will be responsible for the emergency medical expenses. \_\_\_\_\_
- In case of an accidental ingestion of a poisonous substance, I consent to my child being treated as directed by the Poison Control Center. \_\_\_\_\_

### Special Permissions

- I give my permission to this center to apply  sunscreen and  insect repellent to my child. *Please check which product you will permit.* **Initial**  
\_\_\_\_\_
- I understand that I must supply my own sunscreen and/or insect repellent with a valid expiration date, and it will be labeled with my child's name. \_\_\_\_\_
- I have special instructions for the application process.  None  \_\_\_\_\_

Parent initial \_\_\_\_\_ Staff initial \_\_\_\_\_ Date \_\_\_\_\_

## Rate Agreement and Contract

### Hours of Operation

After-School regular operating hours are **Monday through Friday from 2:30 PM to 5:30 PM** except closings for various holidays, as described in the Family Handbook. Please consult the current school calendar for holidays and after-school closings. There is no reduction in tuition as a result of center closures.

Day Camp will operate **Monday through Friday from 7:30 AM to 5:30 PM on days intended for inclement weather, school closings, some holidays, and summer break.** This will not include major holiday breaks, as described in the Family Handbook.

The procedure to notify families should severe weather or other conditions prevent the program from opening on time or at all will be announced via phone call or text message. If it becomes necessary to close early, we will contact you or someone listed in the *Emergency Contact and Release*, and it will be your responsibility to arrange for your child's early pick up.

### Program Fees

Choose from the following	Fee Type	Amount	Description
<input type="checkbox"/>	Child Care Monthly	\$250.00 for first child \$200 for additional children	Child Care Monthly includes both After-School and Day Camp. After-School Care is Monday through Friday from 2:30-5:30 PM. Day Camp is for inclement weather days, school closings, various holidays, and summer break. Hours of operation for Day Camp are Monday-Friday 7:30 AM-5:30 PM.
<input type="checkbox"/>	Child Care Monthly <b>SUMMER MONTHS</b>	\$300 for first child \$250 for additional children	Total fee must be paid prior to enrollment for each month. Payment is due by the 5th day of each month. First month of service may be pro-rated.
	Child Care Weekly	\$90/child \$80 for additional children	Child Care Weekly is for children/families needing weekly care as an option. Normal operation is Monday through Friday from 2:30-5:30 PM or 7:30 AM – 5:30 PM for Day camp on days where there is no school. Weekly payments must be made during the week, no later than Friday, paid in full.
<input type="checkbox"/>	After-School Daily	\$20.00/day/child	After-School Daily Fee is for children not currently enrolled into our monthly program. Normal operation is Monday through Friday from 2:30-5:30PM. Days of attendance must be paid upon arrival.
<input type="checkbox"/>	Day Camp Daily	\$30.00/day/child	Day Camp Daily Fee is for children not currently enrolled. Day Camp is available Monday-Friday 7:30 AM-5:30 PM for inclement weather days, school closings, various holidays, and summer break. Days of attendance must be paid upon arrival.
<input type="checkbox"/>	Mountain Heart	Fee To Be Determined	To apply, visit Mountain Heart Community Services in Princeton, WV or call 304-425-3669. Address: 1411 N. Walker Street Princeton, WV 24740 Fax: 304-425-2301 Toll Free: 1-800-738-8531  If you are already a member of Mountain Heart, one should contact their case worker and provide us with a valid Child Care Certificate before enrolling the child/children into our program.

Additional Comments:

### Fee Policy (to be completed by staff; reviewed and initialed by the parent/guardian/sponsor after completion)

	Initial
- For the first month of <b>attendance</b> , tuition will be pro-rated.	_____
- Tuition is due and payable on the first business day of each month, following the initial payment.	_____
- Tuition is <b>\$250/month</b> and is not subject to discounts for holidays, emergency closures (i.e., weather), or absence.	_____
- I agree to pay the full tuition in advance of services rendered.	_____
- I agree to pay the full tuition fee even if my child is absent for one or more days.	_____
- An additional fee of <b>\$25</b> is due if tuition is not received on time.	_____
- A non-refundable registration fee of <b>\$20</b> is due for first-time registrants.	_____
- Every child must be picked up no later than 5:30 PM. Failure to do so will result in a <b>\$15</b> fee per child per every <b>15</b> minutes past closing time.	_____
- Accounts two weeks in arrears may result in immediate termination of service.	_____
- My child may have the opportunity to participate in a special program or field trip that may have an additional fee due before the day of the event. A specific permission slip may be required.	_____
- All returned checks will carry a fee of \$25. Two or more returned checks will result in my account being placed on "cash only" status.	_____

## Other Agreements

### Private Employment Acknowledgement and Release

Any arrangement/employment between me and staff of this center (i.e., babysitting), outside of the programs and services offered by this center, is an individual endeavor and private matter not connected or sanctioned by this center. This center shall remain harmless from any such arrangement.

Initial \_\_\_\_\_

### Media Release

Occasionally, audio, photos, and video will be taken of the children at the center for use within the center, social media, or on our website. Please indicate that you authorize the use and reproduction of photographs of your child in conjunction with the program.

Initial \_\_\_\_\_

Parent initial \_\_\_\_\_ Staff initial \_\_\_\_\_ Date \_\_\_\_\_

## Other Agreements (continued)

### Walking Excursions

I give my permission for my child to participate in supervised walking excursions near and around the center (e.g., Mitchell Stadium, City Park).

Initial \_\_\_\_\_

### Transportation (only available for Memorial Primary and Bluefield Middle School students)

I give my permission for City of Bluefield Parks and Recreation Department to transport my child from school to the after-school facility.

Initial \_\_\_\_\_

### Arrival and Departure Procedures

#### Arrival

Child will be (please check one of the following)

- Dropped off by Parent/Guardian or Emergency Contact
- Dropped off by Public School Bus
- Walking from BMS (6<sup>th</sup> grade and older)

#### Departure

Child will be (please check one of the following)

- Picked up by Parent/Guardian or Emergency Contact
- Walking (6<sup>th</sup> grade and older)

Initial \_\_\_\_\_

### Handbook Acknowledgement

I understand and agree that it is my responsibility to read and familiarize myself with policies and procedures outlined in the Family Handbook and agree to abide by them.

Initial \_\_\_\_\_

I understand that it is my responsibility to go directly to management with any questions I may have regarding the policies and procedures and information contained in this Enrollment Agreement.

Information contained in the **Family Handbook** may be subject to change.

## Contract Approval

I certify that I have read, understand, and accept all of the terms and conditions described in this *Enrollment Agreement* and the *Family Handbook*.

Primary Parent/Guardian/Sponsor Signature \_\_\_\_\_

Date \_\_\_\_\_

Center Staff Signature \_\_\_\_\_

Date \_\_\_\_\_