

**K.I.N.D. CARE ENROLLMENT FORM**

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Gender \_\_\_\_\_ Nickname \_\_\_\_\_

Home Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Child's Street Address \_\_\_\_\_ PO Box \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

Mother's Full Name \_\_\_\_\_

Is mother's home address and phone same as children? Yes No  
If no, please give address \_\_\_\_\_

Mother's Work \_\_\_\_\_ Work Address \_\_\_\_\_

Mother's Work Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ EXT. \_\_\_\_\_ Cell \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Father's Full Name \_\_\_\_\_

Is father's home address and phone same as child's? Yes No  
If no, please give address \_\_\_\_\_

Father's Work \_\_\_\_\_ Work Address \_\_\_\_\_

Father's Work Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ EXT. \_\_\_\_\_ Cell \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Child's Allergies & Dietary Restrictions \_\_\_\_\_

Child's Favorite Activities \_\_\_\_\_

Child's Talents: \_\_\_ Instrument \_\_\_ Dance \_\_\_ Gymnastics \_\_\_ other \_\_\_\_\_

Child's Special Needs \_\_\_\_\_

Is your child receiving daily long-term medications? Yes No  
Name of medication/s \_\_\_\_\_

Will Kind care need to administer medication **during program hours**? Yes, No

If you answered yes, a **Medication Authorization Form** will need to be signed to give permission to administer medication.

Willing to participate on the Parent Board of Directors for a one year term June - May \_\_\_ Yes \_\_\_ No

**Please pick a 4 digit number** you want to use for signing in/out your child \_\_\_\_\_ mom  
\_\_\_\_\_ dad \_\_\_\_\_ other authorized person

# **Parent Authorization for Emergency Medical/Dental Treatment**

(Permission for medical/dental care in parental absence)

Child's Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

In the event that my child may require **emergency medical, surgical care/ or emergency dental, surgical care** while I am out of the city or unable to be reached, I hereby give my consent to medical and /or surgical treatment, dental care and /or dental surgical treatment to the:

\_\_\_\_\_ Hospital \_\_\_\_\_ Doctor \_\_\_\_\_ Dentist \_\_\_\_\_

Or his /her designee to provide this care. I agree to pay the entire costs and fees contingent on any emergency medical/dental care and/or treatment for my child as secured or authorized under this consent.

Name of parent or legal guardian: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Mother's Work Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Cell Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Father's Work Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Cell Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Doctor: \_\_\_\_\_ Doctor's Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Doctors Address \_\_\_\_\_

Hospital of preference: \_\_\_\_\_ Hospital Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Dentist \_\_\_\_\_ Dentist Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Dentist Address \_\_\_\_\_

## **Person(s) to be contacted in emergency if parents are unavailable**

Name – Work Phone- Home Phone – Relationship

1. \_\_\_\_\_

2. \_\_\_\_\_

This consent will be in effect beginning \_\_\_\_\_

This consent will continue while this child is enrolled at K.I.N.D. Care.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

## **K.I.N.D Care Release Form**

### **Liability**

I \_\_\_\_\_ parent/gaurdian of \_\_\_\_\_ will not hold KIND Care in Williamsburg, IA liable for any injury or accident related to water activities held in conjunction with the daycare. This includes, but is not limited to, trips to the public or private pools, or for any activities held at the daycare center.

\_\_\_\_\_

Date

Signature of Parent/Guardian/Custodian

### **Program Directory Information Release**

I Do, I Do Not, (Circle One) give permission to have the child program directors and staff print the full name of my enrolled child, the name(s) of the parent(s) with whom he/she lives, and the family's home address and phone number, in a directory which will be distributed to all of the families of children enrolled in the program.

\_\_\_\_\_

Date

Signature of Parent/Guardian/Custodian

### **Records Release Authorization**

I hereby authorize and request (name of school) \_\_\_\_\_ to release to K.I.N.D. CARE INC. a copy of the most recent immunization certificate and physical examination record of (name of child) \_\_\_\_\_ Present in their school file.

\_\_\_\_\_

Date

Signature of Parent/Guardian/Custodian

### **Picture Release**

**I Do, I Do Not** (circle one) give permission to have my child appear in any media coverage approved by K.I.N.D. CARE INC.

\_\_\_\_\_ Date

Signature of Parent/Guardian/Custodian

### **Field Trips**

I Do I Do Not (circle one) give permission to have my child participate in center sponsored field trips, swimming, and off site activities.

Signature of Parent/Guardian/Custodian \_\_\_\_\_ Date \_\_\_\_\_

## Pick-UP Authorization Form

(My child may leave K.I.N.D. CARE INC. into the following person(s) care)

1. Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

2. Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

3. Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

4. Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Is there any court order prohibiting contact of your child with any person?  Yes  No If 'Yes' please provide a photocopy or order.

Name of person(s) who **may not** pick up child

\_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

## Inclement Weather Release

**If school is cancelled** or we would have to close due to an unsafe building or weather conditions, the following person(s) has agreed to pick up my child from K.I.N.D. CARE. **The following person(s) is local and could arrive within 1 hour of notification.**

I would like staff to contact me at my employment first,  Yes,  No

Employer phone number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_

**Local Contact** person authorized to pick up my child in the case of severe weather:

Name \_\_\_\_\_

Address \_\_\_\_\_

Daytime Phone Number \_\_\_\_\_

Alternate Name if this person is not available: (Optional)

Name \_\_\_\_\_

Address \_\_\_\_\_

Daytime phone number \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# Iowa School Age Care – Health Status-Parent Statement

(Health statement to be completed by parent or guardian)

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Child's full name

Birth Date

1. Significant illness and or surgeries my child has had (give age at time.)

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2. Any special health-related needs of child (allergies, medications, injuries, etc.)

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3. Is this child subject to any conditions, which limit classroom activities or physical education?

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4. I this child subject to any condition which may result in an emergency situation

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Please ✓ in the  if statement applies to your child

**Play with friends** - My child

- Plays well in groups with other children
- Will play only with one or two other children.
- Prefers to play alone.
- Fights with other children
- I am concerned about my child's play activity with other children.

**Body Health** – My child has problems with

- |  |  |
|--|--|
| <input type="checkbox"/> Skin, hair, fingernails or toenails             | <input type="checkbox"/> Mobility, uses assistive equipment              |
| <input type="checkbox"/> Stomach aches or upset stomach                  | <input type="checkbox"/> Mouth, teeth, gums, tongue, sores in mouth      |
| <input type="checkbox"/> Eyes/vision, glasses or contact lenses          | <input type="checkbox"/> Heart or heart murmur                           |
| <input type="checkbox"/> Using toilet, night time wetting                | <input type="checkbox"/> Breathing, asthma, or on lips, cough            |
| <input type="checkbox"/> Ears/hearing, hearing aides or tubes in ears    | <input type="checkbox"/> Frequent sore throats or tonsillitis            |
| <input type="checkbox"/> Constipation, diarrhea                          | <input type="checkbox"/> Nervous system, headaches, seizures, or nervous |
| <input type="checkbox"/> Nose problems, nosebleeds breaths through mouth | <input type="checkbox"/> Female monthly periods habits (like twitches)   |
| <input type="checkbox"/> Bones, muscles, pain moving                     |  |

**Medication** -My child takes medication

List meds taken at home, school, or in child care. List the name, time medication taken, and reason medication prescribed.

**Allergy** – My child has the following allergies (food, medication, latex, inhalants, insects, animals, etc.):

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**K.I.N.D. CARE  
SUMMER CAMP AGREEMENT 2009**

**Dates/Hours**

Kind Camp will be open for the summer of 2009) M-F 6:00Am - 6:00Pm June 08 through August 14. (Closed Fri. July 3<sup>rd</sup>)

**Attendance**

I will notify KIND CARE Camp staff as early as possible when my child will not be participating or arriving late. I, or a designated adult, will bring and pick up my child at the scheduled their time. All legal parent/guardians will be allowed to pick up their child/ren unless there is a legal document on file at Kind Camp stating otherwise.

I will not permit my child to participate in Kind Camp if he/she is sick. If my child becomes ill at the Program I will arrange transportation for him/her to return home. If a medical emergency arises, the Program staff will first attempt to contact me, if I cannot be reached, or my established emergency people cannot be reached, the staff will contact my child's doctor. If necessary an ambulance or emergency vehicle may take my child to the hospital.

**Absences**

If my child is absent, I will be responsible for payment for the days or weeks my child is contracted. I will give a courtesy call to let a staff know if my child will be absent on any scheduled day. (Part-time status will need to give a 24-hr notice of absence before his/her scheduled day, as a no-call no-show will result in a charge for the missed scheduled day).

**Drop Program Notice**

If for any reason I need to drop the program, I agree to give a pre-paid written 2 week notice.

**Meals**

Kind Camp will provide breakfast, milk at lunch, and pm snack. I agree to send my child a sack lunch that is nutritionally sound on all sack lunch days. My child has the option on Thursdays, to bring \$3.00 to order pizza for lunch.

Sack lunches will have four main rules:

- 1) No trading of food will be allowed
- 2) No pop/soda will be allowed
- 3) No large candy will be allowed
- 4) Use a cool pack if lunch requires cooling

There will be a CACFP approved menu posted in advance in each group area, of the breakfast and snack items.

**Discipline**

I understand that the Summer Program reserves the right to limit participation of any child for disciplinary reasons. I have read the Discipline and Discharge Policy in the parent handbook. \_\_\_\_\_ Please initial

**Fee Policy**

Weekly fees are due in advance on Mondays or the first day of my child's scheduled week. If fees are not paid by Wednesday 6:00PM, a late charge of \$10.00 will be added in the AM of the 4<sup>th</sup> program day. I am responsible for payment for the days and weeks contracted for my child. **If my child is absent** on a scheduled day **I will be** responsible for full payment of that day or week.

My child's start date will be \_\_\_/\_\_\_/2009      Arrival time \_\_\_\_\_ depart time \_\_\_\_\_

\_\_\_\_\_ **Full-time** (5 days per week) contract 7to10 wks @ \$110.00 pr wk

\_\_\_\_\_ **Partial Fulltime** (5 days pr wk) \_\_\_\_\_ contract 1to 3wks @ \$130.00 pr wk      \_\_\_\_\_ contract 4 to6 wks @\$120.00 pr wk

\_\_\_\_\_ **Part-time** (4 or less days per week) contract partial wks @ \$30.00 pr day

**Registration/Activity Fees Full & Part-time**

**Registration fee - \$50.00 (non refundable late reg. add \$15.00 after 4/06**

**Activity fee - \$60.00 (refundable through May 15, 2009) no exceptions.**

**Fundraising**

\_\_\_\_\_ I opt out of fund raising events (I agree to pay an additional \$6.00 pr contracted wk)

\_\_\_\_\_ I opt out of fund raising events (I will make a one time donation of \$60.00)

\_\_\_\_\_ I will participate in fundraising events (I will earn the program a min. of \$60.00 the summer 09) Balances will be billed on your last program week.

I agree to pay **in advance** the following contracted weeks (check one) \_\_\_ Wkly \_\_\_ Bi-Wkly \_\_\_ Monthly.

**Contracted weeks will be as follows:** *Check all that apply*

\_\_\_ Week 1 June 8-12

\_\_\_ Week 2 June 15-19

\_\_\_ Week 3 June 22-26

\_\_\_ Week 4 June 29- July 3

\_\_\_ Week 5 July 6-10

\_\_\_ Week 6 July 13-17

\_\_\_ Week 7 July 20-25

\_\_\_ Week 8 July 27-31

\_\_\_ Week 9 August 3-07

\_\_\_ Week 10 August 10-14

**Consent/Liability**

I give my consent for (child's name) \_\_\_\_\_ to participate fully in the Kind Care Summer Camp Program 2009

I will not hold KIND Care in Williamsburg, IA liable for any injury or accident related to water activities held in conjunction with the daycare. This includes, but is not limited to, trips to the public or private pools, or for any activities held at the daycare center.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date