"FRIENDS" CHILD INFORMATION FORM

Child's Name _____ Date of Birth _____

Age _____ 2016-2017 Grade _____Teacher_____ Social Security # _____

Mother's Name _____ Phone, Home _____ Work _____Cell_____

Address _____ City/State _____ Zip _____

Employer _____ Social Security # _____

Father's Name _____ Phone, Home _____ Work _____Cell_____

Address _____ City/State _____ Zip _____

Employer _____ Social Security # _____

Email Address_____

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List names and phone numbers of three people who are authorized to pick up your child. These people may also be contacted in case of an emergency.

Name: **Relationship to student:** **Phone Numbers:**

1. _____ _____ Home _____Work_____Cell_____

2. _____ _____ Home _____Work _____Cell_____

3. _____ _____ Home _____ Work _____Cell_____

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If parents are divorced, which parent has custody of the child? _____

***List any illness, disabilities, special medications or routines that affect your child's activity:_____**

_____

Does your child have a current health form on file at the Elementary School? Yes _____ No _____

Does your child have medical insurance? Yes _____ No _____
(Must have insurance to enroll your child.)

Child's Physician _____ Phone _____

Preferred Hospital _____

Insurance Co. _____ Policy #_____

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To my knowledge, this information is correct. In the event that I cannot be reached in an emergency, I hereby give my permission to the Site Director or designee to secure emergency medical services, including transportation and physician. I also give permission to the attending physician to order injection, anesthesia, or surgery, if necessary, for my child as name above.

I have received, read, and understand the Parent Handbook, Parent Agreement Form. And the State Child Care licensing requirements. I will allow my child to be photographed for any media event.

Parent Signature _____ Date _____

My Child has my Permission to watch "G"____ And/Or "PG"____ Movies

"FRIENDS" EXTENDED SCHOOL PROGRAM
PARENT AGREEMENT CONTRACT

Date of Admission: _____ Registration Fee: $15.00/Student ____ Paid

Children to Enroll

NAME	AGE	GRADE
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Rates Available: (please circle your choice)

A.M. ONLY 6:00 a.m. – 7:00 a.m. $15.00/week
** Separate contract needed. Must have 5 enrolled to offer this service. **

EARLY BIRD 2:45 p.m. – 4:00 p.m. $35.00/week

PICK UP 2:45 p.m. – 6:00 p.m. $45.00/week

DROP-IN 2:45 p.m.-6:00 p.m. $15.00/day/child

FULL DAY (School Not in Session) 7:00 a.m. – 6:00 p.m. $ 10.00 Added to weekly fee

FAMILY DISCOUNT (3 or more children) $90.00 + $5.00 additional/week/child
Example – 3 children $95.00/week
4 $100.00/week
5 $105.00/week

FALL, CHRISTMAS & SPRING BREAKS $20/day or $90 for the week of
Full Day Rate 7:00 am - 6:00 pm

PAYMENTS ARE DUE EACH WEEK. IF YOU DO NOT PAY YOUR WEEKLY FEE BY FRIDAY OF THE WEEK ATTENDED YOU WILL BE CHARGED A $5.00 LATE FEE EACH WEEK YOU ARE PAST DUE. YOU ARE RESPONSIBLE FOR YOUR WEEKLY FEE REGARDLESS IF YOUR CHILD ATTENDS.
Rates are subject to change.

I understand this is a contract between the Blount County Extended School Program and myself. I will pay the fee of $_____ each week and will notify the site director if this contract needs to be changed. Otherwise I will be responsible for this amount. This fee may vary upon full days and holiday breaks.

I have read and understand the parent handbook, parent agreement form and State Licensing Requirements.

Parent Signature: _____ Date: _____

STUDENT HEALTH HISTORY

Student health information within the school is limited to the information necessary to serve the student's educational and health interests.

Student Name _____ Grade _____ Date _____
Please let us know your child's health needs by completing this form.

___ **My child has no health problems which would affect his/her school day.**
___ My child's health needs include the conditions checked (X).
___ Allergies, please list _____
What happens_____
Is EpiPen prescribed? ___yes ___no (If yes, parent must provide EpiPen)
___ Bee Sting Allergy, What Happens?_____
Is EpiPen prescribed? ___yes ___no (If yes, parent must provide EpiPen)
___ Asthma, is inhaler used? ___yes ___no If yes, how often? _____
What medications are taken for asthma?_____
___ Diabetes, What medications are taken? _____
Any special procedures during the school day?_____ __
___ Hearing Problem, Please describe _____
___ Vision Problem, Wears glasses? ____yes ____no Wears contacts? ____yes ____no
___ ADD or ADHD Diagnosed, What medications are taken?_____
Will medication be needed in school? ___yes ___no When?_____
___ Bone/Joint problem or fractures, Which bone or joint?_____
Is a brace worn? ___yes ___no
___Seizures, What type? _____Date of last seizure _____
Medication taken _____
___Episode of loss of consciousness, When? _____
Any special treatment?_____
___Emotional concerns, List _____
List any other recurrent medical problem or illness you would like the school to be aware of
_____
_____
Name of Student's doctor _____Phone_____
Does your child see a specialist? ____yes ____no Name _____
Phone _____

Please contact school personnel for medication forms if your child needs medication at school, including inhalers for asthma or EpiPen for severe allergic reactions. Your child may carry an inhaler if medically authorized and developmentally appropriate, after informing school personnel.

Health History Informed Consent
Your signature gives permission for school staff to take precautions and procedures to protect your child in the classroom and to foster academic success. Your signature is an informed consent to share this health history information with school staff on a need-to-know basis for emergency plans.

Parent/Guardian signature _____ Date _____

Phone number _____

Policy Agreement

Due to the fact that the Blount County Extended School Program is totally funded through parent's tuition, the staff will strictly enforce the following policies:

___ Payments are due by Friday the week of service rendered. Rates are subject to change.

___ You will be charged a late fee of $5.00 per week, for each week you do not pay.

___ If you do not pay by the end of two weeks, you will be asked to leave the program.

___ All payment for services rendered must be remitted within one month. If payment is not made by this time, your fee will be turned over to a collection agency and you will be responsible for all applicable attorney's fee and collection costs.

___ Our Elementary School programs close promptly at 6:00 pm. You will be charged a late fee of $1.00 per minute per child for each minute you arrive after the closing time.

___ You must sign your child up in advance for full days throughout the school year. If you fail to do so, service may not be available. If services are available and you do not meet the deadline for sign up, you will pay the drop in rate of $25.00/day/child.

___ You are required to fulfill any commitment for full days or for summer care regardless if your child attends.

If you have any questions about the above policy, contact your site director or Kathy Smith at 984-1212 ext. 2244.

I have received, read, understand and agree to the above policies set forth by the Blount County Extended School Program.

Child's Name_____

Parent/Guardian Signature:_____ Date:_____