



GUILFORD BEFORE & AFTER SCHOOL CARE PROGRAM
 280 South Union Street • Guilford, CT 06437 • (203) 453-0045
[HTTP://GUILFORDCENTERFORCHILDREN.COM](http://GUILFORDCENTERFORCHILDREN.COM)
2017-2018 APPLICATION FOR CHILD CARE

| | |
|---------------|--------------------------|
| Today's Date: | First Day of Attendance: |
|---------------|--------------------------|

CHILD'S INFORMATION

| | | | | |
|------------------------------|------|------|--------------------------|--------|
| Child's First and Last Name: | | | | |
| Date of Birth: | Sex: | Age: | Language spoken at home: | Phone: |
| Home Address: | | | | |

SCHOOL INFORMATION

| | | | |
|---------|--------------------|----------|----------------|
| School: | Grade: (2017-2018) | Teacher: | School Bus # : |
|---------|--------------------|----------|----------------|

MEDICAL INFORMATION

| | |
|--------------------|--------|
| Child's Physician: | Phone: |
| Child's Dentist: | Phone: |

ALLERGIES or SPECIAL DIET:

SPECIAL ACTIVITY or HEALTH NEEDS:

REGULAR MEDICATIONS: Please contact the Director for the appropriate forms before your child begins. Regular medications (inhalers, epi-pens) need to be on site prior to your child's first day of attendance.

PARENT/GUARDIAN INFORMATION

PARENT/GUARDIAN INFORMATION

| | |
|---|---|
| Name: | Name: |
| Home Address: (If different from child) | Home Address: (If different from child) |
| Home Phone: | Home Phone: |
| Cellular/Pager: | Cellular/Pager: |
| Email: (Please indicate primary) <input type="checkbox"/> | Email: (Please indicate primary) <input type="checkbox"/> |
| Employer: | Employer: |
| Work Address (Street, Town, State & Zip code): | Work Address (Street, Town, State & Zip code): |
| Work Phone: | Work Phone: |
| Occupation (optional): | Occupation (optional): |

| TYPE OF CHILD CARE NEEDED: | Monday | Tuesday | Wednesday | Thursday | Friday | Unscheduled |
|-------------------------------------|--------|---------|-----------|----------|--------|-------------|
| Before School Care 7:00AM-9:00AM | | | | | | |
| After School Care 3:25PM- 6:00PM | | | | | | |

AUTHORIZED PICK UP/EMERGENCY CONTACT LIST: Please list AT LEAST five (5) people who are authorized to take your child from the program, including yourself and spouse, if applicable. All persons may also be contacted in case of an emergency and you cannot be reached.

| <u>NAME</u> | <u>PHONE AND ADDRESS</u> | <u>RELATIONSHIP TO CHILD</u> |
|--------------------|---------------------------------|-------------------------------------|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |

- I understand that my child will be released **ONLY** to those listed on my Emergency Contact/Authorized Pick Up List and agree to amend my list as needed. I also understand that when my child has been released to one of the above named people, his or her welfare is no longer the responsibility of the Guilford Before and After School Care Program.

Parent or Guardian Signature

Date

PLEASE SIGN THE FOLLOWING STATEMENTS INDICATING YOUR AGREEMENT:

- My child has permission to go on walking field trips while attending the Guilford Before and After School Care Program.

Parent or Guardian Signature

Date

- I give permission for the Guilford Before and After School Care Program to photograph my child while involved in child care activities. Photographs may be placed on our bulletin boards for parent and children viewing. I understand that my child's full name will be disclosed only with prior permission.

Parent or Guardian Signature

Date

PLEASE SIGN THE FOLLOWING STATEMENTS INDICATING YOUR AGREEMENT (Continued):

- I give my permission for the staff to access the health records that I have provided to the Program for my child.

Parent or Guardian Signature

Date

- The staff has permission to evaluate simple injuries and apply first aid if necessary. In the event of serious injury or illness and if I cannot be reached, my child [_____] has permission to be treated by his/her Physician [_____], the Program's physician/dentist consultant, by the medical personnel if 911 is called or hospital emergency services. If 911 is called and transportation by ambulance is necessary, I give my permission for that transport.

Parent or Guardian Signature

Date

FOR BALDWIN MIDDLE SCHOOL STUDENTS ONLY:

- I give my permission for the bus company to provide transportation for my child from Baldwin Middle School to A. W. Cox, Calvin Leete, or Guilford Lakes After School Program.

Parent or Guardian Signature

Date

THE FOLLOWING SECTION IS OPTIONAL: This additional information will help us serve your child's needs.

OTHER CHILDREN IN YOUR HOUSEHOLD: (Name, Age, School, Grade)

HOLIDAYS OR SPECIAL EVENTS CELEBRATED AT HOME:

ACTIVITY OR HOBBIES:

**APPLICATION CONTINUES ON PAGE 4
(PARENT - PROVIDER CONTRACT REQUIRED FOR ENROLLMENT)**

PARENT - PROVIDER CONTRACT

My child, [_____], is enrolled in the Guilford Before and After School Care Program for the 2017 - 2018 school year.

- I will provide a copy of my child's current physical exam prior to enrollment. (Please do **NOT** request a copy from the school nurse.)
- I understand that if my child has an allergy, they will be unable to attend the program until all appropriate paperwork and proper medication with labels are received by the Guilford Before & After School Care Program.
(PLEASE NOTE: Authorization forms must state "Child Care Personnel" to be accepted by GBASC)
- I agree to pay the initial registration fee (\$50/child or \$65/family) during registration and ALL appropriate child care fees at the beginning of each week during which care is provided. If monthly payments are agreed to, these fees are due at the beginning of the month.
- I agree to pay late pick up fees, if they are assessed, in accordance with the policy.
- I understand that fees are due for all days contracted for regardless of whether or not my child attends.
- I agree to provide a two-week notice in writing to the Director prior to changing from SCHEDULED to UNSCHEDULED days or WITHDRAWING from the program and understand I am responsible for payment for these two weeks.
- In addition to any bank charges I will be charged a \$25 fee for returned checks due to insufficient funds.

I have read and agree to follow the policies and procedures as outlined in the Parent Handbook. Also, at the time of enrollment the discipline policy, behavior management, health, medication administration and schedule changes have been explained and discussed by the Program Director.

Parent or Guardian Signature

Date

The Guilford Before and After School Care Program agrees to provide written notification of all changes in policies and two weeks notice for any change in fees.

Program Director's Signature

Date