



AFTER SCHOOL PROGRAM ENROLLMENT FORM

(JR KINDERGARTEN- 4TH GRADE)

CHILD'S NAME: _____ GRADE (2019/2020) _____

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/Late Start 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)

.NAME (Print) _____ PHONE _____

.NAME (Print) _____ PHONE _____

.NAME (Print) _____ PHONE _____

EMERGENCY PHONE NUMBERS:

. NAME (Print) _____ PHONE _____

. NAME (Print) _____ PHONE _____

. 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: _____

MEDICATION POLICY: Parent/Guardians – You are responsible for your child’s medication. After School Program staff **WILL NOT** be responsible for administering medication to your child during this program.

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: _____

COPY OF IMMUNIZATION RECORD IS REQUIRED AT REGISTRATION _____

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 _____