MECHANICVILLE AREA COMMUNITY SERVICES CENTER INC.

WHISTLE STOP LEARNING CENTER ENROLLMENT FORM

Please be sure to complete all of the information requested in this application.
Incomplete applications will be returned to the parent/guardian.
ALSO NOTE: By completing the following information and submitting for enrollment, the responsible parent/guardian verifies that they are in understanding of all policies, regulations, and payment expectations pertaining to the Mechanicville Area Community Services Center Whistle Stop Learning Center.

(Please Print)

CHILD'S INFORMATION

Child's last name:	First:	Middle:	❑ Male ❑ Female	Grade:	Home Phone:
Street address:					Birth date: / / Age:
City		State			Zip Code:

Parent / Guardian # 1

Parent / Guardian Last Name:	First:	Middle:	Employer:	Employer phone #: ( )
Street address:				
City:	State		Zip Code:	
Home Phone:	Cell Phone:		Email Address:	

Parent / Guardian # 2

Parent / Guardian Last Name:	First:	Middle:	Employer:	Employer phone #: ( )
Street address:				
City:	State		Zip Code:	
Home Phone:	Cell Phone:		Email Address:	

Please circle one:
In Case of Emergency who should be called first: Parent / Guardian #1 Parent / Guardian #2 Either

EMERGENCY CONTACT

In the event of an emergency and neither parent can be contacted, please provide two alternate emergency contact names. Please remember to inform these people that they are listed as your emergency contacts.

Last Name:	First:	Relation to Child:	Home Phone: ( )	Alternate Phone: ( )
Last Name:	First:	Relation to Child:	Home Phone: ( )	Alternate Phone: ( )

BILLING

Person(s) responsible for bill: 1.	Address if Different:	Phone #:
2.		

Does your child qualify for the DSS Child Care Subsidies program? ❑ Yes ❑ No

AUTHORIZATION FOR PICK UP

Parent's Marital Status:	If Separated or Divorced who has legal custody?	Is Child's time divided between parents because of divorce or separation? ❑ Yes ❑ No

Please note that unless there is a legal document ON FILE with the program office stating that one parent is not allowed contact with a child, staff is NOT legally able to keep a non-custodial parent from picking up the child/ren. Please attach a copy of a legal document to this form if this situation applies to you.

I give permission for the following people to (must be over 18 years of age) to pick up my child/ren at the Mechanicville Area Community Services Center (MACSC) WSLC Program. I realize that my child/ren will not be released to anyone who is not listed below unless MACSC or WSLC is informed with written permission.

I also understand that if a staff member does not recognize a parent or someone else on this child's pick up form, the staff person may ask for identification. It will be my responsibility to assure that each of the individuals listed below will have proper identification if required to present it to the WSLC staff.

Additionally, all WSLC staff reserve the right not to release a child to anyone that smells of, or presents to be under the influence of drugs or alcohol.

Last Name:	First:	Relationship to Child:	
Home Phone:	Work Phone:		Cell Phone:
Last Name:	First:	Relationship to Child:	
Home Phone:	Work Phone:		Cell Phone:
Last Name:	First:	Relationship to Child:	
Home Phone:	Work Phone:		Cell Phone:

HOLD HARMLESS

I give my child/ren permission to participate in all programs and activities provided through the Mechanicville Area Community Services Center. I understand that my child/ren may be photographed and his/her name may be used for publicity purposes for the WSLC.

I absolve and hold harmless the Mechanicville Area Community Center, its staff, and volunteers of any liability in the event of an accident or emergency occurring while my child is participating in any of the WSLC's sponsored programs. Any and all accidents must be reported to the parents, Child Care Director and Executive Director within 24 hours.

Parent/Guardian Signature:	Date:

MECHANICVILLE AREA COMMUNITY SERVICES CENTER, INC.

CHILD'S MEDICAL FORM

Child's Name: _____

Health History: For all questions checked please give date of diagnosis and current management below, if appropriate.

	ALLERGIES	DISEASES
☐ Vision Impairment ☐ Hearing Impairment ☐ Frequent Ear Infections ☐ Heart Defect/Disease ☐ Diabetes ☐ Convulsions/Seizures ☐ Asthma ☐ High Blood Pressure ☐ Lung Disease ☐ Bleeding/Clotting Disorder ☐ Kidney Disease ☐ Cancer	☐ Hay Fever ☐ Ivy Poisoning, Etc. ☐ Penicillin ☐ Insect Stings Further Detail: _____ _____ _____ _____	☐ Chicken Pox ☐ Measles ☐ Shingles ☐ German Measles ☐ Mumps Further Detail: _____ _____ _____

Does your child need to take medication during program hours? ❑ Yes ❑ No ***If yes please see Director for a written medication form.***

Is child allergic to any food, or medications/drugs other than those shown above?

_____

List any/all Medications child is currently taking:

_____

Is child on a special diet? If so, explain:

_____

Should child be restricted in recreation or swimming? In what way?

_____

Has child been under any medical care within the past three months? If so, explain:

_____

Mental and/or emotional growth normal for child's age?

_____

Anything else we should know about your child?

_____

MEDICAL FORM (continued)

IMMUNIZATION HISTORY – To be filled in by doctor, or parent.

To your knowledge, are all shots up to date and meet the NYS Health requirements? Yes No

The NYS Dept. of Environmental Health requires an immunization history filled out as completely as possible, for each camper under the age of 16. Please notify camp if child is exposed to any communicable disease during the 3 week prior to camp (especially chicken pox or shingles)

DPT (diphtheria pertussis, & tetanus)	1st	2nd	3rd	Booster	Booster
POLIO (oral)	1st	2nd	3rd	Booster	Booster
MEASLES* (red/hard)	Date	RUBELLA *	Date	MUMPS	Date
VARICELLS (CHICKEN POX)	Date	Booster	Booster		
HIB (hemophilus Influenza Type B)	1st	2nd	3rd	Booster	
HB (Hepatitis B)	1st	2nd	3rd	Tuberculin Test Given?	Y N Date:

** MMR (measles, mumps, rubella) triple vaccine is usually given together.*

If above information is supplied by Physician or School Nurse, please Provide signature:
Name: _____Signature: _____ Date: _____
Name of Dentist: _____Phone: _____
Name of Orthodontist: _____Phone:_____
Name of Primary Care Physician: _____Phone:_____
Do you carry family medical/hospital insurance? Yes No
If yes, Carrier: _____Policy or Group #: _____

Consent for Medical Treatment (Parent/Guardian)

This health history is correct as far as I know. I give permission for the above named camper to participate in all prescribed camp activities except as noted on summer calendar. I also give permission for the above named camper to be given first aid in case of emergency, while he/she is in attendance at the Mechanicville Area Community Services Center School Aged Child Care Program. This includes permission for the child to be taken to the Emergency Department of a local hospital, if the injury is serious enough to require medical attention. I understand that I will be notified as soon as possible. I hereby waive and release The Mechanicville Area Community Services Center and its employees of any liabilities or claims in association with anything that might occur while my child is attending the School Aged Child Care Program.

_____ _____

Parent/Guardian Signature: Date:

MECHANICVILLE AREA COMMUNITY SERVICES CENTER, INC.

Whistle Stop Learning Center
2008-09

This contract is entered into by and between _____of _____
(Parent/Guardian) (Billing Address)
_____ hereinafter "Parent" and the Mechanicville Area Community Services Center
(Address)
Hereinafter "Provider", for the purpose of securing arrangements for child care of _____
Hereinafter "Child/ren". (Name of Child or Children)

The Parent Agrees:
1: To pay the Provider the rate of $200 per week for pre-school and, for child care services for their child/ren. (Subject to Change)
2. To pay the provider on Friday of each week. $10 late fee will be assessed if payment is not received by noon Monday.
3. To pay an **overtime rate of $10** per 15 minutes when the child/ren is picked up late. (Late fee may be waived if prior notice is given to Provider by the Parent.)
4. To pay a $20.00 fee for all returned checks in addition to any bank charges. (Any outstanding debts shall prohibit my child/ren from enrolling or participating in the WSLC Program or any other MACSC Programs until debt is paid in full.)
5. To **have backup child care arranged** in the event of an emergency or illness of the provider.
6. To pay the full scheduled fee regardless of whether child/ren is absent. If child/ren is seriously ill, or a special circumstance arises, arrangements may be made at the discretion of the Financial and Child Care Directors.
7. To give two week written notice to the Child Care Director of any temporary absence from the program. Failure to give notice will result in Parent being responsible for payment of scheduled time even though child/ren was absent.
8. To give two weeks written notice of Parent decision to withdraw child/ren from School Aged Child Care Program permanently. Failure to give notice will result in Parent being responsible for payment of scheduled time even though child/ren was withdrawn.
9. To read and become familiarized with all policies in the family handbook.

The Provider Agrees:
1. To provide child care services for the above named child/ren for the hours and days stated below except in the case of illness and/or emergency.
2. To provide a safe environment for the children.
3. To provide appropriate activities and toys for the children.
4. To communicate with the parent about the needs and achievements of the child.

Both Parent and Provider Agree:
1. That the hours and days of child care shall be Monday – Friday 6:45am-6pm
2. That child care will not be provided if the child is considered to be too ill to receive care.
3. That parents may visit or call at any time during normal child care hours to discuss or check on their child/ren.

If there is a court ordered document regarding child care payments please attach a copy of your child's application. If there is a payment arrangement between parents/caregivers, please inform us of who is responsible for what percentage of payments. All responsible parties must sign below.

Mother: _____ Father: _____ Guardian/other: _____

I have read and understand the above policy.

Parent Signature(s) _____ **Date**_____

_____ **Date**_____

Provider Signature _____ **Date**_____