Camp of Dreams Schools
Site_____

Date of Application_____
Entered into Database_____
Amount Received_____

☐ New Enrollment ☐ Returning

☐ K-2 ☐ 3-5 ☐ 6-8

Camp of Dreams After School
Registration 2014-2015

☐ **5 Day Option or Select Days:** □Mon □Tues □ Wed □Thurs □Fri

Child Name_____
Last First Middle

Age_____Date of Birth_____Grade_____School_____

Address_____Chicago, IL Zip Code_____

Phone_____
Home Cell

□Male □Female Height_____ Weight_____ Skin Color_____
Identify Features Hair Color_____ Eye Color_____ Birth Marks_____

Dietary Restrictions/Food Allergies_____

Religious or Other Special Considerations_____

Parent/Guardian (1) _____
Relationship to Child ☐Mother ☐Father ☐Grandparent
☐Other Relative ☐Foster Family ☐Other_____
Phone_____
Home Cell Work

Home Address_____**Chicago, IL** _____
Street Number, Name & Apt.

Work/School_____**Hours at Work/School**_____**Email**_____

Parent/Guardian (2) _____
Relationship to Child ☐Mother ☐Father ☐Grandparent
☐Other Relative ☐Foster Family ☐Other_____
Phone_____
Home Cell Work

Home Address_____
Street Number, Name & Apt.

Work/School_____**Hours at Work/School**_____**Email**_____

_____
Parent/Guardian Signature Date

Medical History and Emergency Consent Form

Emergency Contact Information (please provide 2 not including parent/guardian)

Adult Contact #1

Name_____Relationship to child_____

Local Address_____

Street City State Zip

Phone_____

Home Work Cell

Adult Contact #2

Name_____Relationship to child_____

Local Address_____

Street City State Zip

Phone_____

Home Work Cell

Health and Developmental History

In order to serve your child best, please provide the following information below:

1. Allergies (bee, food, medication) □ yes □ no _
2. Seizures/Epilepsy □ yes □ no _
3. Hearing/Vision Impairments □ yes □ no _
4. Chronic Illness (asthma, diabetes) □ yes □ no _
5. Serious Illness □ yes □ no _
6. Emotional concerns/disorder □ yes □ no _
7. Nosebleeds □ yes □ no _
8. IEP/ Special Limitations* □ yes □ no _

*If your child is on an Iindividual Education Plan, please contact your school student services office to schedule an appointment for accommodations or provide the IEP with registration.

9. **List all Medications □ yes □ no _

If your child will be taking any medications while during after school hours, we will need the **medication with the prescription label. Please read and sign below.

Name of Medication:_____Time/Dosage:_____

Reason for medication:_____Directions for storage:_____

I,_____give permission to authorized staff member(s) to administer medication to my child as indicated above.

Date of last physical examination_____

List of Immunizations and date of last Booster and Tetanus:_____

Child's Physician/Clinic_____

Address_____Phone_____

Insurance Information and Policy #_____

In case of an emergency, your child will be taken to Somerville Hospital, or the nearest hospital for treatment unless otherwise specified here:_____

I authorize Camp of Dreams staff that is trained in the basics of first aid/CPR to give my child first aid when appropriate. _____

Signature Date

Transportation Plan

Child Name_____

Last First Middle Initial

My child will arrive to the program by:

□ Supervised Walk by Teacher

□ Other (describe)_____

My child will depart from the program by:

□ Unsupervised Walk

□ Supervised Walk by who_____

□ Program Van

□ Parent Pick up

□ Other (describe)_____

Authorization for Dismissal from Program

I give permission for my child to be released from the program:

□To the adults listed as **Emergency Contacts** on page 2 of this registration packet

□**NO ONE** except the **Parent/Guardians** listed on page 1 of this registration packet

ANY OTHER TRANSPORTATION REQUESTS MUST BE STATED IN WRITNG AND MAINTAINED IN THE CHILD'S FILE OR THE ABOVE PLAN MUST BE IMPLEMENTED. PLEASE INFORM PROGRAM STAFF OF ANY CHANGES. VERBAL OR WRITTEN PERMISSION AND PICTURE ID IS REQUIRED FOR ANYONE NOT INCLUDED ON LIST ABOVE.

_____

Parent/Guardian Signature Date

Allergy Alert!

Please be advised that there may be students that attend **Camp of Dreams' After School Program** who have food allergies including ALL NUTS (peanuts and tree nuts) and EGGS. Please do not pack any food from home that may contain nuts or egg.

Please notify program administration about any additional food and/or other allergies to ensure immediate action to keep all campers safe.

2014-2015 Parent/Guardian Contract

Child Name_____

Last First Middle Initial

By signing this contract, I agree to terms below:

1. I understand that payment is due in advance and that my child will not be permitted to stay at the program if the fee has not been paid.

2. I understand that payments are based on a flat daily fee and will **NOT** be pro-rated days not attended, including sick days and suspension days.

3. All tuition payments must be made by cash, credit card (processing fee of 2.75% will be incurred) ,check or money order. I understand that there will be a $20.00 fee assessed to my account for returned checks. (Two (2) returned checks will result in cash or money order payments for the remainder of the year).

4. I authorize Camp of Dreams to administer basic first aid and CPR or to seek medical care in the event of an emergency. I understand that the program staff will make every reasonable attempt to contact me, should injury occur.

5. **I hereby consent to my child(ren)'s participation in Camp of Dreams' activities, including field trips requiring transportation and other off-site activities such as: visits to local parks, libraries, neighborhood walks, etc daily from 4:00pm (2:00pm on early release days) to 6:00pm. In giving this consent, I agree that I will not bring suit against program staff or their employers for damage or personal injury incurred by my child while participating in program activities.**

6. I understand that Camp of Dreams reserves the right to dismiss any participant for continual behavior issues consistent with the behavior management policy in the handbook.

7. Photographs and/or video recordings may be taken during the program for use by Camp of Dreams for materials and/or submitted to the media.

8. I agree to adhere to the program hours and will pick up my child no later than **6:05pm**. I understand that a fee of $5.00 per child per quarter hour or any portion there of or a flat $20.00, whichever is the lesser will be assessed for late pick up.

9. I understand it is my responsibility **to update all contact information** as necessary.

Cancellation Policy: Withdrawal from the program requires a one week written notice. The cancellation date will be counted from the date the written notification is received. Cancellations should be directed to the executive director or program director at the Camp of Dreams office only.

_____

Parent/Guardian Signature Date

Child and Family Individualized Information

In order to provide the best care to your child, please complete the following information.

Is your child receiving any special education services? □ Yes □ No
(IEP, sheltered classroom, occupational therapy, speech therapy, counseling)

_____

_____

_____

How would you describe your child's behavior on a typical day and what is the best type of discipline (i.e. plays well with others, is withdrawn, is energetic, taking space/timeout is helpful)?

_____

_____

_____

Does your child require assistance during transitions such as to the restroom, another activity such as an enrichment club or specialized assistance during homework time?

_____

_____

_____

What are some of the activities you feel your child will enjoy while at the After School Program?

_____

_____

Family Information

Family Size (including yourself and any adults that live in your household)	Total #	Adults #	Children #
Housing (Check one)	☐Live with Relatives ☐Own home	☐Rent Apartment ☐Housing ☐Homeless	☐Shelter ☐Other
Living Situation (Check all that apply)	☐2 Parents ☐Female Headed ☐Foster	☐Grandparent ☐Male Headed	☐Teen Parent ☐Other
Marital Status (Check one)	☐Divorced ☐Married	☐Separated	☐Single
Parent's Primary Language Spoken at home (Check one)	☐African dialect ☐Chinese dialect ☐English	☐Haitian Creole ☐Portuguese	☐Spanish ☐Other
Employment Status Parent/Guardian 1	☐Employed Full Time ☐Employed Part Time	☐Unemployed ☐ Disabled	☐Attending School ☐DTA Assistance
Employment Status Parent/Guardian 2	☐Employed Full Time ☐Employed Part Time	☐Unemployed ☐ Disabled	☐Attending School ☐DTA Assistance

Child Information

Child's Languages (Check all languages that the child speaks)	☐African dialect ☐Chinese dialect ☐English	☐French Creole ☐Portuguese	☐Spanish ☐Other
Child's Ethnicity (Check one)	☐African American ☐African ☐Asian	☐Cape Verdean ☐Caribbean ☐Caucasian	☐Haitian ☐Hispanic ☐Other

_____

Parent/Guardian Signature Date

Parent/Guardian Signature Date