

IPS Fall Intersession 2011



Program AYS @ First Meridian Heights Presbyterian Church

Child's Name: _____ Grade _____

Regular AYS Program _____

Parent/Guardian 1: Name _____

Home # _____ Cell # _____ Work# _____

Parent/Guardian 2: Name _____

Home # _____ Cell # _____ Work# _____

Physician _____ # _____

Medication/Special Needs(Attach all Forms) _____

Emergency Names & Numbers:

1. _____ # _____

2. _____ # _____

Authorized Pick Up Names & Numbers in addition to those listed above:

1. _____ # _____

2. _____ # _____

Parent Signature _____

Mark the dates your child will be attending. \$109 a week or \$35 a day

WK 1	10/10	10/11	10/12	10/13	10/14	WK 2	10/17	10/18	10/19	10/20	10/21

Fee \$ _____ (Total due)

Type of Funding _____ Co-pay \$ _____ Voucher change date _____

Director/Office Use Only:						
Amount Owed	Amount Paid	Options	Date	CK, MO #	Balance	Initial

Family Registration Form - 2011-2012



A registration fee per family is required with enrollment.

If guardian or emergency contact information varies among children, please use a separate form for each child. Otherwise, one form is sufficient with copies for each Program Site (if more than one).

PARENT/GUARDIAN #1 (Payment Contact/Primary Payer)

Last _____ First _____ Relationship to Child _____ Home Phone: () _____
 Address: _____ Street _____ City _____ State _____ Zip _____ Pager/Cell: () _____
 Email: _____ (Internal use only)
 Business Name/Address: _____ Work Phone: () _____
 Mark all that apply: Child lives with Emergency Contact Authorized pickup

PARENT/GUARDIAN #2

Last _____ First _____ Relationship to Child _____ Home Phone: () _____
 Address: _____ Street _____ City _____ State _____ Zip _____ Pager/Cell: () _____
 Email: _____ (Internal use only)
 Business Name/Address: _____ Work Phone: () _____
 Mark all that apply: Child lives with Emergency Contact Authorized pickup

1st Child

Last _____ First _____ MI _____ Birthdate: ____/____/____ Ethnicity: <input type="checkbox"/> Af.Am. <input type="checkbox"/> Asian <input type="checkbox"/> Cauc. <input type="checkbox"/> Hisp. <input type="checkbox"/> Multi Racial <input type="checkbox"/> Other Teacher _____ Grade in Fall ____ Gender M F Who has legal custody of the child and what is the relationship _____ Custody Agreement Y N If Y, please provide copy.	AYS Program Site
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FIRST DATE OF ATTENDANCE (REQUIRED) ____/____/____
ENTER ATTENDANCE PLAN BELOW IN APPLICABLE BOX (REQUIRED)

SCHOOL AGE AND ALL-DAY KINDERGARTEN	
FULL TIME (5 DAYS)	PART TIME (3 DAYS OR LESS)
AM&PM _____	AM&PM _____
AM Only _____	AM Only _____
PM Only _____	PM Only _____
Days Attending: M T W TH F	
Emergency Only _____	

HALF-DAY KINDERGARTEN/EARLY CHILDHOOD		
HALF-DAY KINDERGARTEN	AYS SCHEDULE	EARLY CHILDHOOD
SCHOOL SCHEDULE (circle one)	(check one)	(check one)
AM	Over 4 hours _____	Over 4 hours _____
PM	Under 4 hours _____	Under 4 hours _____
(Attend AYS before and after KG) (Attend AYS after AM KG or before PM KG)		

Are there any special needs to consider? If so, a special needs **INTAKE FORM** is required with registration.

ADD or ADHD _____	Autism _____	Hearing or Visually Impaired _____	IEP (Individual Education Plan) _____
Allergies _____	Diabetes _____	Learning Disabilities _____	Behavior Management Plan _____
Asthma _____	Epilepsy _____	Physical Disabilities _____	Other _____

2nd Child

Last _____ First _____ MI _____ Birthdate: ____/____/____ Ethnicity: <input type="checkbox"/> Af.Am. <input type="checkbox"/> Asian <input type="checkbox"/> Cauc. <input type="checkbox"/> Hisp. <input type="checkbox"/> Multi Racial <input type="checkbox"/> Other Teacher _____ Grade in Fall ____ Gender M F Who has legal custody of the child and what is the relationship _____ Custody Agreement Y N If Y, please provide copy.	AYS Program Site
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HALF-DAY KINDERGARTEN/EARLY CHILDHOOD		
HALF-DAY KINDERGARTEN	AYS SCHEDULE	EARLY CHILDHOOD
SCHOOL SCHEDULE (circle one)	(check one)	(check one)
AM	Over 4 hours _____	Over 4 hours _____
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Allergies _____	Diabetes _____	Learning Disabilities _____	Behavior Management Plan _____
Asthma _____	Epilepsy _____	Physical Disabilities _____	Other _____

For more children, complete additional form with all child information and parent name only.

EMERGENCY NUMBERS-- ANY CHANGES MUST BE IN WRITING. ID will be required to pick up.

Give two local people who can be reached during program hours if a parent or guardian is not available **(required)**.

Name / Relationship to child: _____ Phone: () _____

Name / Relationship to child: _____ Phone: () _____

Additional people authorized to pick up your child (optional).

1) _____ Phone: () _____

2) _____ Phone: () _____

INSURANCE/MEDICAL INFORMATION

Insurance Company _____ Policy Number _____

Name of Family Physician _____ Physician Phone # () _____

Name of Dentist _____ Dentist Phone # () _____

MARKETING/PUBLIC RELATIONS

If new, how did you hear about AYS? Referral _____ Web _____ School _____ Other _____

I would like to help someone less fortunate attend AYS who might otherwise be unable to participate. My tax-deductible gift added to my registration fee is: \$10 _____ \$25 _____ \$50 _____ \$100 _____ Other _____

PAYMENT METHOD (Additional form required for credit card payments - see Program Director, web site, or call the AYS office)**

Credit card payment	<input type="checkbox"/>	CCDF Voucher (prior approval needed)	<input type="checkbox"/>	(Call AYS office)
Check/Money Order at site (NO CASH)	<input type="checkbox"/>	Other Funding	<input type="checkbox"/>	(Call AYS office)
		Prepaid drop-in pass	<input type="checkbox"/>	(Occasional use only)

ENROLLMENT TERMS

_____ For the school year, I agree to pay \$ _____ (circle one) weekly/monthly/semester/prepaid pass.

Initial (If you need assistance in calculating your fee, please contact your Program Director or the AYS Office).

_____ I agree to pay the **Friday in advance** of service based on my plan (or first of month or semester if applicable)

Initial regardless of actual attendance.

_____ I agree to adhere to AYS policies outlined in the Parent Handbook (available on-line). Hard copy of handbook needed.

Initial

_____ I give permission for AYS and my child(ren)'s school to share educational, behavioral and other pertinent information regarding my child(ren) with AYS.

Initial

_____ I give permission for my child(ren) to be included in any promotional/media resources related to AYS and/or the school.

Initial

_____ If I cannot be contacted in the event of emergency, I give permission to AYS staff to secure emergency medical treatment for my child(ren).

Initial

_____ A **two week notice** is required for program withdrawal and reduction in hours attending. An increase in hours attending can be made immediately (if space permits as approved by Program Director).

Initial

After Sept. 1, a \$15 fee will be charged for each attendance plan change at time of request.

_____ Costs to collect delinquent fees (i.e. collection agency fees, court fees, attorney fees) will be paid by me. Delinquent accounts will be handled by the AYS main office.

Initial

_____ If applicable, I give permission for my child(ren) to be transported from _____ school to the AYS program site and agree to pay the fee related to this service.

Initial

I certify that I am the parent or legal guardian of this child(ren) and I have the legal authority to make the representations and grant the authorizations contained herein. I also understand and agree to the financial obligations and enrollment terms as outlined above.

X _____
Signature of Parent or Legal Guardian Relationship to Child

X _____
Printed Name

Child(ren) Names _____ Date **X** / /

AYS STAFF USE ONLY - FINANCE		
	Initials	Date
Received by Finance	_____	_____
Entered in parent database	_____	_____
Confirmation to parent	_____	_____
Copy to applicable programs	_____	_____



AYS STAFF USE ONLY - PROGRAM	
Date: ___/___/___	Amt. Received: _____
Registration Fee: Check # _____	M.O. # _____
1st Wk. Deposit: Check # _____	M.O. # _____
Handbook Distributed: Y N	
Separate Credit Card Agreement (NO CARD #'S ON THIS FORM):	Y N
Orientation Checklist: Y N	
AYS Staff Initials: _____	



Parent Orientation Checklist

Welcome to AYS:

_____ I have completed all of the paperwork needed to register my child, including all
Initial special needs and medication forms.

_____ AYS opens at _____ and closes at 6:00PM. There is \$1.00 per minute late fee
Initial after 6:00PM according to the AYS clock. This is paid directly to the staff member, not included with regular fees.

_____ I can consult my Parent Handbook, the site Director, or AYS administration with
Initial any questions or concerns about the program.

_____ I will not send a sick child to the program. Please consult the AYS Sick Policy handout.
Initial Any medication (prescription and non-prescription) given at the program requires written permission.

_____ I will notify AYS if my child will not be attending the program on his/her regularly
Initial scheduled day.

_____ My child will be signed in/out each day by an authorized person. This is an individual
Initial who is listed on the registration form. A picture ID will be required.

_____ I will notify AYS of any changes such as: address, phone, custody, pick-up list or
Initial something else that concerns my child.

_____ I realize payments are **due Friday** for the following week and payments are
Initial due regardless of attendance. No cash please. Payments will NOT be adjusted due to illness or holidays/school closings. Winter, Spring, and Summer break fees are charged separately.

_____ If applying for financial assistance, I understand that full rates must be paid until
Initial the application is complete and approved by the AYS Finance Office.

_____ I will give a two week written notice if withdrawing my child from the program.
Initial

_____ After Sept. 1, a \$15 fee will be charged for each attendance plan change at time of
Initial request. A two week notice is required if reducing number of days attended. An increase in days attended can be made immediately (if space permits as approved by the Program Director).

_____ Voucher Families Only: I agree to swipe in and out daily and comply with all
Initial voucher requirements.

_____ ****Early Childhood only:** I will provide a change of clothes for my child. (Don't forget
Initial the child's name on all items.)

I HAVE READ AND AGREE TO THE POLICIES AND PROCEDURES LISTED ABOVE:

Parent/Guardian Signature

Date

Director Signature

Date



AYS, INC

HEALTH RECORD

Child's Name _____ Birth Date: _____

Program: _____

MEDICAL HISTORY

Child's Physician: _____ Phone #: _____

Date of most recent physical: _____ Age of child at time of physical: _____

Date of last tetanus shot: _____ Blood type, if known: _____

Local Hospital preference: _____

Health Insurance Company: _____ Membership #: _____

Child's Dentist: _____ Phone #: _____

Does your child have any allergies: YES / NO Explain, if yes: _____

Does your child have any diagnosed health conditions: YES / NO Explain, if yes: _____

Are there any special routines prescribed by your child's doctor that should be included in AYS' plans for your child's activities? YES / NO Explain, if yes: _____

Are there any modifications of normal activities that would be necessary to protect your child and his / her classmates? YES / NO Explain, if yes: _____

Does your child take any medication(s) every day? YES / NO If yes, list name and dosage of medication(s), time given, & purpose of medication(s). ***See Below*** _____

A form must be on file each year for any medication, either prescription or non-prescription, to be administered during the AYS program. Prescription medication requires a doctor's signature to be administered by AYS personnel.

(Over)

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Child's name _____ Program _____

HISTORY OF IMMUNIZATIONS & TEST (indicates month / day / year)

	1	2	3
Hepatitis B			

	1	2	3	4
Hib				

	1	2	3	4	5
DTP/DTaP					

	1	2	3	4
Polio				

	1	2	3	4
Pneumococcal Conjugate/ Pevnar/ PCV/ PCV 7				

	1	2
Measles		

	1	2
Mumps		

	1	2
Rubella		

	1	2
Varicella		

**If your child has had chickenpox, he/she does not need the vaccine.

Please provide us with the date (month & year) of the infection along with your signature:

Date of chickenpox infection: _____ Parent Signature: _____

NOTE: To be considered adequately immunized, a child of age twenty-four months should have received 3 Hepatitis B vaccinations, 4 DTP vaccinations, 3 Polio vaccinations, 3-4 Hib vaccinations, 4 PCV vaccinations, 1 vaccination against Measles, Mumps, and Rubella, and 1 Varicella vaccination.

Parent / Guardian Signature _____

ADDITIONAL NOTES AND INSTRUCTIONS
