The Arc
McLennan County

SUMMER DAY CAMP

ENROLLMENT AGREEMENT

1. I understand that I am enrolling my child, _____, in The Arc's **Summer Day Camp** Program being held at 1300 Austin Avenue (inside **Austin Avenue United Methodist Church**) Waco, Texas 76701. Hours of operation are 7:30 a.m. to 5:30 p.m.
2. I understand that this Program will be for eight (8) weeks from **June 15 thru August 7, 2015 (off Friday, July 3rd)**. I will update my child's file information as changes occur.
3. During full camp days (7:30 am to 5:30 pm), my child will attend Monday through Friday and arrive at about _____ a.m. She/he will be picked up each day at about _____p.m. For part-time camp (5 hours or less), my child will arrive at _____a.m. and she/he will depart at _____p.m. Most camp field trips are in the mornings.
4. I understand that there is a **$25.00 non-refundable registration fee**. I also understand there is an annual Arc **membership fee of $20.00** that must be current or paid at time of enrollment for attendance in Summer Day Camp.
5. I understand that I am responsible for payment of **weekly camp fees** in the amount of $200.00 for full days (7:30 a.m.-5:30 p.m., or over 5 hours) or $125.00 for half days (up to 5 hours; i.e. 7:30 a.m.-12:30 p.m.). These weekly fees are due the Friday prior to attendance week for all campers.
6. I understand that in the event of any absences during Program hours activities, I will be responsible for fees for time reserved, not actual time spent at the Program (**no per diem for care**). Should my child be absent during a day, or several days, the fee is still the same for the entire week.
7. I further understand that I am responsible for notifying The Arc ahead of time when my child **WILL NOT** be attending the program by calling **756-7491**. Voice mail is available to leave a message. I will give seven (7) days notice in writing prior to withdrawal from the program during which time I will be responsible for payment of fees.
8. The Program staff will assume full responsibility, as deemed reasonable, for my child from the time she/he arrives at the Program until my child leaves the Program.
9. If a medical emergency arises, the Program staff will first attempt to contact me. If I cannot be reached, the staff will contact my child's doctor. If the emergency is such that immediate hospital attention is necessary, an ambulance or emergency vehicle may take my child to the hospital**.**

I agree to adhere to the Policies and Procedures of The Arc's Summer Day Camp as stated here and therefore give my child permission to participate fully in this Program.

_____

Signature Date

_____

Relationship to Child

Submit this completed statement accompanied by the non-refundable enrollment fee of $25.00, membership fee of $20.00, first week's fees, and completed enrollment forms to The Arc by Friday, May 15, 2015.

The Arc™
McLennan County

Program Use: Date of receipt _____ First date of attendance _____

Summer Day Camp 2015 Enrollment Form

1. Child's Identification

_____

Child's Name Date of Birth Sex

_____

Address City Zip Phone Number

If child does not go by his/her first name, what does he/she prefer to be called?

_____

School Child Attends: _____

2. Parent(s)/ Guardian(s)/ Custodian(s) Identification:

1. _____

Name Relationship to Child

_____

Address City/Zip Home Phone

_____

Employer Department

_____

Work Phone Work Hours

Child resides with above? (Circle) Yes No

Please explain arrangement if applicable: _____

2. _____

Name Relationship to Child

_____

Address City/Zip Home Phone

_____

Employer Department

_____

Work Phone Work Hours

Child resides with above? (Circle) Yes No

Please explain arrangement if applicable: _____

Prefer to be contacted first: (circle) #1 or #2

Parent's Status:

Single_____ Married_____ Divorced_____ Separated_____

Is there a separation or divorce custody problem of which the Program staff should be aware?

If yes, please explain: Yes _____ No _____

_____

_____

If your child has a childcare provider who will be picking him/her up, please list information:

_____

Name Contact #

Emergency Persons:

These should be local persons who may be notified in case of emergency or illness when the parents or other caregivers are not available.

_____

Name Relationship with Child Work #

_____

Address Home #

_____

Name Relationship with Child Work #

_____

Address Home #

_____

Name Relationship with Child Work #

_____

Address Home #

Release of Child:

May child leave the Program with the persons listed above? (Please check below)

_____ Yes, he/she may depart with any of the persons listed

_____ No, he/she may not leave with the following person(s) (include any person not listed):

_____

_____

Child's Information:

Does your child have any eating problems or food allergies?_____

_____

What type of foods does your child like to eat for a snack? _____

_____

How does your child get along with other children? _____

_____

When you discipline your child, how do you do this? _____

_____

_____

What makes your child upset? _____

_____

How do you suggest we calm your child down? _____

_____

_____

Does your child tire easily? _____

_____

Does your child bite, hit, pinch, etc? Explain:_____

_____

Is your child sensitive to any stimulus we should know about? _____

_____

Please give any further information that you believe will be helpful to staff in understanding and caring for your child: _____

_____

Diapered? Yes_____ No_____ **Work on Toilet training**: Yes_____ No_____

Note: **Parents must supply diapers and/or feminine hygiene products.*

Other siblings in the home:

Name	Date of Birth	Enrolled in program?

Medical Information:

Diagnoses: _____

_____

Allergies (food, medication, bees) _____

_____

Chronic or recurrent illnesses or disorders: _____

_____

_____

Does your child take medication for these illnesses listed above? If so, please state the name of the drug and the dosage. _____

_____

Will the medication need to be given during program hours? _____ Yes _____ No

If yes, when will it need to be given? _____

Describe how. _____

_____

_____

What should we (you) do if your child has a problem related to his/her medical condition during program hours? _____

_____

_____

What are the signs of problems that may occur? _____

_____

Please list an **emergency phone number**: _____

Doctor's Name: Phone #

_____

What hospital do you prefer? _____

Insurance Company _____

Policy Holder's I.D. _____

Medical Consent:

In the event that my child, _____, (Birthdate) _____,
may require medical and/or surgical care while I am out of the city or unable to be reached, I hereby give my consent to medical and/or surgical treatment to _____
Hospital and Doctor _____ or his/her designee to provide this care.

I agree to pay all the costs and fees contingent on any emergency medical care and/or treatment for my child as secured or authorized under this consent.

_____

Signature of Parent/ Guardian **Date**

THE ARC OF Mc LENNAN COUNTY SUMMER DAY CAMP PROGRAM
RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT

1. This is a release. Read it carefully before signing. By signing this release, you are giving up your and your child's rights to sue The Arc of McLennan County, a Texas nonprofit corporation, its agents, officers, volunteers, employees and any parties that operate, administer, co-organize or provide transportation to or from the activities described below (collectively, the "Released Parties") or expect the Released Parties to be legally responsible or pay for any damages or medical expenses if your child is injured or killed, becomes ill or your child's belongings are damaged as a result of your child's participation in the activities described below.

2. Voluntary Participation. I acknowledge that my child(ren) _____ (my "Child"), and I have voluntarily chosen for my Child to (a) participate in THE ARC OF MC LENNAN COUNTY SUMMER DAY CAMP, a day program administered by the Released Parties, for summer day childcare, which may include numerous activities, including, but not limited to, sports, hikes, arts and crafts, science experiments, cooking projects, and possibly, field trips to various locations by private car and bus including bowling alleys, sporting events, movies and fairs, any activities incidental thereto and (b) be present at or use, as applicable, facilities, other locations, equipment and/or transportation provided by the Released Parties or others in connection with my participation in such activities (the activities in clauses (a) and (b) are referred to collectively as the "Activity").

3. Acknowledgement and Acceptance of Risks. My Child and I understand that certain risks are inherent in the Activity, and that these risks cannot be eliminated, altered or controlled. My Child and I understand that the risks that contribute to the unique character of the Activity can also be the cause of my Child's injury, illness or death or damage to my Child's belongings. My Child and I voluntarily elect, with knowledge of the risks involved, for my Child to participate in the Activity. My Child and I acknowledge and willingly assume all risks and hazards in the Activity and in the use of the Released Parties' facilities and/or equipment.

4. **Release. I am the parent or legal guardian of my Child. In consideration for my Child being permitted to participate in the Activity, my Child and I voluntarily agree and promise not to make a claim against, sue or attach the property of the Released Parties, and my Child and I release, waive, discharge and hold harmless the Released Parties for all demands, actions or claims of liability arising out of their negligence, fault, recklessness or any other act or omission that causes my Child's illness, injury, death and/or damage to me or my Child's property as a result of my Child's participation in the Activity and in the use of the Released Parties' facilities and/or equipment.**

5. Knowing and Voluntary Execution. I have read this document in its entirety. I understand that by signing this document, my Child and I are assuming all the risks of the Activity. I understand that this is a release of any and all claims. I understand that this is the entire agreement between us and the Released Parties and that it cannot be modified or changed in any way by oral statements by any Released Parties or by us. I voluntarily sign my name as evidence of the acceptance by me and my Child of all the provisions in this document and our agreement to be bound by them.

6. Media Release. I give permission for The Arc of McLennan County to have my child appear in any media coverage and use for publicity and fundraising purposes photographs of my child.

Signature of Parent or Legal Guardian: _____

Name: (Print Clearly): _____ **Date:** _____

The Arc™
McLennan County

EMERGENCY INFORMATION

Child's Name: _____

Doctor's Name: _____

Doctor's Phone Number: _____

Insurance Information:

Name of Company: _____

Policy/Group Number: _____

_____

Other: _____

Which hospital do you prefer for your child: (Circle One)

Hillcrest **Providence**

Parent Name & Contact Number: _____

_____

_____

_____

Date **Signature - Parent/Guardian**

The Arc™
McLennan County

PARENTAL EMERGENCY MEDICAL CONSENT

This form must be presented upon admission for treatment.

Child's Full Name: _____ Birth Date: _____

In the event that my child (listed above) may require medical and/or surgical care while I am out of the city or unable to be reached, I hereby give my consent to medical and/or surgical treatment to _____ Hospital and Doctor _____ or his/her designee to provide this care. I agree to pay all the costs and fees contingent on any emergency medical care and/or treatment for my child as secured or authorized under this consent.

1. Parents/Guardians/Custodians With Whom The Child Resides:

1. Name _____ Relationship to Child _____
   Address _____
   City _____ Zip Code _____ Home Phone _____
   Employer _____ Work Phone _____
2. Name _____ Relationship to Child _____ Address _____
   _____
   City _____ Zip Code _____ Home Phone _____
   Employer _____ Work Phone _____

2. Persons Who Are Authorized To Pick Up Child If Parents Are Unavailable:

1. Name _____ Relationship to Child _____
   Address _____
   City _____ Zip Code _____ Home Phone _____
   Employer _____ Work Phone _____
2. Name _____ Relationship to Child _____
   Address _____
   City _____ Zip Code _____ Home Phone _____
   Employer _____ Work Phone _____

3. Custody Restraints/Person(s) Who May NOT Pick Up Child:

1. Name _____ Relationship to Child _____
2. Name _____ Relationship to Child _____
3. Name _____ Relationship to Child _____

4. Information:

Doctor _____ Phone _____
Address _____ City _____ Zip _____
Last Tetanus _____ Allergies _____
Medication _____
Religious Preference (Optional) _____
Insurance Company _____ Policy Holder's I.D. _____

This consent will be in effect beginning (date) _____ and continuing while the child is enrolled in this facility.

_____

Signature Parent/Guardian **Date** **Signature Parent/Guardian** **Date**

The Arc™
McLennan County

PHYSICAL ASSESSMENT AND HEALTH FORM

1. HEALTH STATEMENT - TO BE COMPLETED BY PARENT.

Child's Full Name_____ **Birth Date**_____

1. What is this child's diagnosis: _____

2. Significant illnesses and surgeries child has had (give age at time): _____

_____

_____

3. Any special health-related needs of child (allergies, medications, injuries, etc.):

_____

_____

2. PHYSICAL ASSESSMENT - To be completed by a physician or his/her designee.

1. Is there any condition of vision, hearing or speech of which the child care program should be aware, or could compensate for by appropriate action? _____

_____

2. Is this child subject to any conditions which limit classroom activities or physical education? _____

_____

_____

3. Is this child subject to any condition which may result in an emergency situation?

_____

4. Is this child subject to any mental or physical condition for which he/she should remain under periodic medical observation?_____

_____

5. Are immunizations up to date? _____ Yes _____ No
If no, what is needed? _____

_____

6. Other significant findings: _____

_____

7. He/She **IS** **IS NOT** (Circle One) physically and emotionally able to participate in the Program. Recommendations: _____

_____

Doctor's Name _____ Phone_____

Doctor's Signature _____ Date of Examination_____

P.O. Box 3367 - Waco, Texas 76707 - Phone: (254) 756-7491 - FAX: (254) 756-7504

The Arc™
McLennan County

MEDICATION AUTHORIZATION

I DO I DO NOT (CIRCLE ONE)
allow The Arc of McLennan County's Summer Day Camp Staff to administer medication to my child,
_____ (Child's Name).

Will The Arc Camp Staff be administering medication to your child on a daily basis? (Circle One)
NO YES

List Medications:

MEDICATION AMOUNT TIME METHOD
(FEEDING TUBE, BY MOUTH)

_____
_____
_____

List any other medications and amounts that The Arc Staff may administer to your child during summer camp hours. (i.e., Tylenol, Advil, Aspirin, Benadryl etc.)

_____
_____

_____
Parent's Signature

Texas Dept of Family and Protective Services

AUTHORIZATION FOR DISPENSING MEDICATION

Form 7238
May 2005

PARENT'S AUTHORIZATION

Name of Child to Receive Medicine		Name of Medication
Prescribing Physician	Prescription No.	Expiration Date
Dosage	When to Give	Continue Medication Until (date)

NOTE: Medication must be in its original container and labeled with your child's name and the date medication is left at the facility. Medication can only be administered in amounts according to the label directions.

Signature-Parent or Guardian _____ Date _____

CAREGIVER'S RECORD OF ADMINISTERING MEDICATION

CHILD'S NAME	NAME OF MEDICATION	DATE GIVEN	TIME GIVEN	AMOUNT GIVEN	FULL NAME OF CAREGIVER OR EMPLOYEE

Disposition of Left-over Medication

☐ Returned to Child's Parent/Guardian ☐ Thrown Away Date:

ADMISSION INFORMATION

Operation Name	Director's Name	
The Arc of McLennan County Summer Day Camp	Erin Flood	
Child's Full Name	Child's Date of Birth	Child's Home Telephone No.
Child's Home Address		
Date of Admission / Date of Withdrawal		
Parent's or Guardian's Name	Address (if different from child's address)	

List telephone numbers below where parents/guardian may be reached while child will be in care:

Mother's Telephone No.	Father's Telephone No.	Guardian's Telephone No.	Cell Phone No

Give the name, address and phone number of person to call in case of an emergency if parents / guardian cannot be reached: | Relationship

I hereby authorize the childcare operation to allow my child to leave the childcare operation **ONLY** with the following persons. Please list name & telephone number for each. Children will only be released to a parent or a person designated by the parent/guardian after verification of ID.

CHECK ALL THAT APPLY:

1. ☐ TRANSPORTATION: I hereby ☐ give ☐ do not give – consent for my child to be transported and supervised by the operation's employees:

Walk home ☐ for emergency care ☐ on field trips ☐ to and from home ☐ to and from school

2. ☐ FIELD TRIPS: I hereby ☐ give ☐ do not give – my consent for my child to participate in Field Trips:

Parent's Comments:

3. ☐ WATER ACTIVITIES: I hereby ☐ give ☐ do not give – my consent for my child to participate in Water Activities:

☐ sprinkler play ☐ splashing/wading pools ☐ swimming pools ☐ water table play

4. ☐ RECEIPT OF WRITTEN OPERATIONAL POLICIES:

I acknowledge receipt of the facility's operational policies including those for discipline and guidance.

5. I UNDERSTAND THAT THE FOLLOWING MEALS WILL BE SERVED TO MY CHILD WHILE IN CARE:

☐ **None** ☐ **Breakfast** ☒ **AM Snack** ☐ **Lunch** ☒ **PM Snack** ☐ **Supper** ☐ **Evening Snack**

6. MY CHILD IS NORMALLY IN CARE ON THE FOLLOWING DAYS AND TIMES:

☐ Mondays	from:	to:
☐ Tuesdays	from:	to:
☐ Wednesdays	from:	to:
☐ Thursdays	from:	to:
☐ Fridays	from:	to:
☐ Saturdays	from:	to:
☐ Sundays	from:	to:

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician:	Address:	Ph.#:
Name of Emergency Medical Care Facility:	Address:	Ph.#:

I give consent for the facility to secure any and all necessary emergency medical care for my child.

_____

Signature - Parent or Legal Guardian

List any special problems that your child may have, such as allergies, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information which caregiver's should be aware of:

Child daycare operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800)-514-0383 (TTY).

_____ _____

Signature – Parent or Legal Guardian Date

ADMISSION INFORMATION

SCHOOL AGE CHILDREN:

☐ My child attends the following school:

_____ _____
Name of School and Address | School Ph.#

CHECK ALL THAT APPLY:

☐ His / her immunization record is on file at the school and all required immunizations and/or tuberculosis test are current. Vision and Hearing screening records are also on file.

Name of sibling(s):

My child has permission to:
☐ walk to or from school or home,
☐ ride a bus, and/or
☐ be released to the care of his/her sibling(s) under 18 years old.

IMMUNIZATION RECORD:

☐ I have provided the childcare operation with a copy of my child's most current immunization record.

ADMISSION REQUIREMENT: If your child does not attend pre-kindergarten or school away from the child-care operation, one of the following must be presented when your child is admitted to the child-care operation or within one week of admission.

Please check only one option:

1. ☐ HEALTH-CARE PROFESSIONAL'S STATEMENT: I have examined the above named child within the past year and find that he / she is able to take part in the day care program.

3. ☐ Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.

4. ☐ My child has been examined within the past year by a health care professional and is able to participate in the day care program.
☐ Within 12 months of admission, I will obtain a health care professional's signed statement and will submit it to the child-care operation.

Name and address of health care professional:

☐

Signature - Parent or Legal Guardian | Date

VISION	R 20/ _____	L 20/ _____	☐ PASS ☐ FAIL
SIGNATURE _____		DATE _____	

HEARING	1000 Hz	2000 Hz	4000 Hz	
R				☐ PASS ☐ FAIL
L				
SIGNATURE _____		DATE _____		

_____ _____
Signature – Parent or Legal Guardian | Date