



BOYS & GIRLS CLUBS
OF PROVIDENCE

SCHOOL AGE CHILD CARE APPLICATION

Please Indicate: **Before School** _____
After School _____
Vacation Only _____

Office Use Only:		
_____ Before School	_____ Membership Card #	_____ Expiration Date
_____ After School	_____ Medical Form	
_____ Vacation Only		
_____ Bus	_____ Walker	_____ Van _____ Time of Daily Pick Up
_____ PP	_____ DHS	_____ CoPay _____ Certificate # _____ DHS Expiration
_____ Deposit Received	_____ Receipt #	_____ Group #

NAME: _____ MALE _____ FEMALE _____

BIRTH DATE: _____ AGE: _____

ADDRESS: _____ PHONE: _____ CELL: _____

CITY: _____ STATE: _____ ZIP: _____

PREVIOUS CHILDCARE PROGRAM: YES NO

NAME OF PROGRAM: _____ LAST ATTENDED: _____

SCHOOL: _____ GRADE: _____ TEACHER'S NAME: _____

MOTHER'S SS#: _____ FATHER'S SS#: _____

MOTHER/GUARDIAN: _____ FATHER/GUARDIAN: _____

PLACE OF EMPLOYMENT: _____ PLACE OF EMPLOYMENT: _____

PHONE: _____ CELL: _____ PHONE: _____ CELL: _____

EMERGENCY CONTACT (Other than Parent)

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

(Phone #'s are required to complete child's application)

Other person(s) you permit to pick up your child:

NAME: _____ NAME: _____

NAME: _____ NAME: _____

Please Note: A Completed Health & Physical Exam Record Form is Required to Complete

Registration.

ADDITIONAL MEDICAL INFORMATION

Medical Insurance Coverage Plan: _____ #: _____

Allergies: _____ Medication Currently Taking: _____

Special Conditions: _____ Restrictions: _____

PARENTAL PERMISSION: I give my child permission to participate in Child Care activities including field trips that may occur as part of the program. The Boys & Girls Club is also authorized to pick my child up from school.

X _____
Parent/Guardian's Signature

Date



Name of Child: _____

Mother/Guardian: _____

Father/Guardian: _____

Persons Authorized for Release of Child

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Parent/Guardian: _____ Date: _____

Code # _____



Name of Child: _____

Mother/Guardian: _____

Father/Guardian: _____

Persons Authorized for Release of Child

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Parent/Guardian: _____ Date: _____

Code # _____

PARENT PAY POLICY

- Payments need to be made by Friday one week in advance. Please have exact change when making payment. Payment may be made by check, money order, debit card, Master Card/Visa or American Express.
- Parents must pay tuition in full including DHS co-payments no later than closing on Monday, or closing on Tuesday during a holiday week. If payment is not made by the close of our program on those days, your child will not be able to attend the Child Care program the following day.
- A childcare balance must be current or the child cannot register for a new session.
- A childcare balance must be current or the child cannot participate in club programs including sports and educational programs.
- Once a child is registered tuition remains the same regardless of periodic illness, holidays, snow days, etc. Your child is entitled to 2 weeks of vacation without payment during the school year. Please submit request for vacation in advance.
- For Summer Funtastic, you are responsible to pay tuition for those weeks you have selected even if the child does not attend. As long as staff is given a two week written notice of any changes, fees will not be charged.
- During the school year there will be a \$5.00 fee charged if a parent doesn't call the club by 1:00 pm stating their child does not need to be picked up from their school.
- There is a late fee for children who are not picked up by 6:00 pm. A \$10.00 fee will be charged for every 15 minutes you are late. Late fee has to be paid on arrival.
- There is a \$10.00 fee for any returned checks. If two checks are returned, all future payments must be made by money order.

_____ Child's Name

_____ Parent Signature _____ Date

_____ Childcare Director's Signature

DAY CARE CENTER

PARENT AUTHORIZATION FOR EMERGENCY TREATMENT

In consideration of admittance, I hereby authorize

_____ Name of Day Care Provider

to arrange for medical examination and/or treatment of my child,

_____ Name of Child

should an emergency arise at the day care center or on a field trip. It is understood that a conscientious effort will be made by the day care provider to contact me at the emergency numbers I have provided below before any medical action is taken.

I would prefer to have my child taken to the following hospital if the need arises:

_____ Hospital

I understand that choice of hospital

may be limited by service of local rescue squad.

_____ Signature-Mother/Guardian

_____ Home Phone

_____ Business Phone

_____ Signature-Father/Guardian

_____ Home Phone

_____ Business Phone

Insurance Company _____

Policy Number _____

Relatives or other persons to be contacted in an emergency:

Name _____

Name _____

Address _____

Address _____

Phone _____

Phone _____

Relationship to Child _____

Relationship to Child _____

_____ Date

Boys and Girls Clubs of Providence
SCHOOL AGE CHILD CARE SERVICE

MEDICAL HISTORY – HEALTH RECORD

Child's Name _____ Age _____

Address _____ Birth date _____
Street and Number

_____ City _____ State _____ Zip code _____

Please note: In order for your child to attend any day care center in Rhode Island, you must provide an immunization record and evidence of a pre-admission physical examination by a licensed physician.

Please complete the information below and use the reverse side of this form for the physical examination.

Health History: (Check- any potential problem for which staff should be prepared.)

Frequent Colds _____ Ivy, Oak, Sumac Poisoning _____
Frequent Sore Throats _____ Allergies (Bee sting, ect.) _____
Stomach Upsets _____

Has your child had a tuberculin skin test? Yes _____ No _____
If yes, indicate: Date _____ Positive _____ Negative _____

Medications Currently being taken: _____

Are there any conditions which should be brought to the attention of the staff?

PARENT/GUARDIAN AUTHORIZATION FOR EMERGENCY MEDICAL CARE

IN CASE OF EMERGENCY, I hereby authorize the Boys and Girls Clubs of Providence to arrange for medical examination and/or treatment for my child. I would prefer to have my child, if the need arises, taken to _____ Hospital.

X _____ Date _____
Signature of Parent or Guardian

PRE-ADMISSION IMMUNIZATION RECORD AND HEALTH EXAMINATION

Child's Name _____ D.O.B. _____

Address _____

I. IMMUNIZATIONS (Date Administered: month/day/year)

Hepatitis B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
DTaP/DTP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
OPV/IPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
MMR	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Varicella	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Other	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Other	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___

DTaP: Diphtheria, Tetanus, acellular Pertussis DTP: Diphtheria, Tetanus, Pertussis DT: Diphtheria-Tetanus Hib: Haemophilus influenzae type b IPV: Inactivated Polio Vaccine OPV: Oral Polio Vaccine MMR: Measels, Mumps, Rubella Varicella: Chicken Pox

*Combination Vaccines should be documented by specific vaccine type, NOT by the manufacturer's product name. For example, HepB-Hib should be documented under both HepB and Hib and NOT Comvax (the manufacturer's product name).

Immunization Exemption (Medical contraindications to vaccine(s) listed above please explain): _____

II. LEAD SCREENING (Required at least annually for children under 6 years of age)
 Student is in compliance with lead screening requirements. YES ___ NO ___

III. OTHER

Tuberculin skin test: Date _____ Results: _____
 Health examination: Date _____ Results: _____

Does the child have any conditions or limitations that the caregiver should be aware of such as allergies, seizures, etc.? YES ___ NO ___

If yes, please specify _____

COMMENTS: _____

Date _____

Physician Signature _____



BOYS & GIRLS CLUBS
OF PROVIDENCE

I, _____ will be away/vacationing with my child/children
_____ the week of _____ to _____.

Your signature allows the Boys & Girls Club to account for one of the two weeks allocated for vacation time during our full year programming. Away/Vacation time that exceeds the two weeks allowed by the Boys & Girls Club program will result in you (the parent) being charged. Failure to notify the Director of Child Care, Assistant Director, or Child Care Leader in writing will result in a charge of your account.

Failure to notify us of a child not return for more than 5 consecutive days after the vacation date will result in removal from pick - up list and make re - enrollment necessary.

Parent Signature

Date



PARENTAL PERMISSION SLIP - SCHOOL DISMISSAL FOR CHILD CARE

I hereby give permission for my child(ren) _____
(Name(s) of Child(ren))

To be dismissed from _____ for the After School
(Name of School)

Childcare Program at the _____ Branch of Boys & Girls Clubs of Providence. I

understand that the regular time of dismissal for my child(ren) is _____
(Time)

*Boys & Girls Clubs of Providence Copy

(Parent's/Guardian's Signature)

(Telephone Number)



PARENTAL PERMISSION SLIP - SCHOOL DISMISSAL FOR CHILD CARE

I hereby give permission for my child(ren) _____
(Name(s) of Child(ren))

To be dismissed from _____ for the After School
(Name of School)

Childcare Program at the _____ Branch of Boys & Girls Clubs of Providence. I

understand that the regular time of dismissal for my child(ren) is _____
(Time)

*School Copy

(Parent's/Guardian's Signature)

(Telephone Number)