SCHOOL YEAR PACKET 2020-2021

INSTRUCTIONS FOR COMPLETION

1. Registration Information:

This form will give us the details regarding your child's schedule as well as other registration information.

1. Please fill out the form and choose your child's schedule.
2. Please initial top right box saying you understand and agree to everything laid out in our handbook.
3. Please sign and date the bottom of the form saying you understand the contracted program outlines and agree to the given schedule and the responsibility of payment for the agreed upon schedule.

2. Agreement:

This is a state mandated form. Please complete the following:

1. Fill in "Name of Child"
2. Fill in "Person(s) Designated by Parent to Whom Child May be Released"
3. Check box regarding program information
4. Check box regarding emergency information
5. Sign and date

An administrator will complete the fee amount and per-day-week boxes with you.
**Please do not sign Periodic Review at time of enrollment.*

3. Emergency Contact/Parental Consent Form:

This is a state mandated form. Every line must be completed. Ditto marks and "same as above" are not accepted. Please make sure the sections asking for addresses are filled out completely, including for the persons to whom the child may be released.

There must be **3 people listed for emergency contacts and 3 people to whom the child may be released.** The mother and father listed at the top of the form are assumed, but they may be listed again under the emergency contact and pick up persons if you do not have 3 other people to list outside of the parents for either section.

There are **3 signatures** required at the bottom of the form. The blocks with Emergency Medical Care and Minor First Aid are often missed.

4. Physical, Medical & Dietary:

This form is designed to help us properly give your child the best possible care pertaining to any special circumstances as well as our medical waiver. Please complete the form and sign and date the bottom of the form for both waivers.

5. Child Health Report:

The state requires a copy of your child's most current Health Assessment and Immunization Records within 30 days of enrollment. The form that comes back to us may look different than the one attached, but it needs to cover the same basic health information and full immunizations and be authorized and ***signed*** by a physician. You are also able to ask the nurse at your child's school for a copy of their kindergarten or 6th grade physical and immunizations and we are able to use this. These are the only grades that require updated physicals and our program adheres to the same policy. However, if your child receives updated immunizations, a new form is required.

Colonial Sports School Year 2020-2021
REGISTRATION CONTRACT

Parent Initials ☐

I have read and agree to the terms in the handbook.

Child's Name: _____ **Start Date:** _____

School: _____ **Grade:** _____

Parent Email: _____ **Gender:** _____

How did you hear about Colonial Sports School Year Program?

____ Returning Parent ____ Website ____ About Families ____ Social Media ____ Referred by Friend ____ Other

Registration Fee: $35 ☐ **Early-Bird:** ☐

Please select the care you need below. Full time care constitutes as all 5 days (Monday - Friday). Part Time care is 4 days or less. If Part Time, please check the days of care needed. Flex is a PM care **ONLY** option. Flex means you have the ability to give us a varying weekly schedule; however, the following week's schedule MUST be communicated to Colonial Sports by the Friday prior to the week of care needed. Care cannot be guaranteed for any Flex contracted schedules that are submitted past the Friday due date. If you have any questions regarding which type of care is most suitable for you, please ask one of our administrative staff.

Select Program (choose one):

Before and After School ☐ Full Time (5 days) **OR** ☐ Part Time ____M ____T ____W ____Th ____F (Check days needed)

*AM & PM **MUST** be same days

Before School Care ☐ Full Time (5 days) **OR** ☐ Part Time ____M ____T ____W ____Th ____F (Check days needed)

After School Care ☐ Full Time (5 days) **OR** ☐ Part Time ☐ Flex (PM only, schedule will vary) ____M ____T ____W ____Th ____F (Check days needed)

Holiday Camp Only ☐ Holiday Camps and/or Snow days only

Upon selection of a program option, you will then be contracted for the 2020-2021 school year and held responsible for weekly tuition unless withdrawn from the program. Under contracted care, you are responsible for paying for your child's weekly tuition, regardless of sick days, vacations, and other absences. In addition, please make sure to communicate any absences as soon as possible in order to avoid added fees. For more detailed information regarding contracted status details, fees, and tuition, please refer to the Handbook.

I understand the contracted program guidelines, agree to the above weekly schedule, and acknowledge responsibility for weekly tuition regardless of attendance.

_____ _____ _____

Parent or Guardian Name (Printed) **Parent or Guardian Name (Signature)** **Date**

AGREEMENT

55 PA CODE CHAPTERS 3270.123 &.181(C); 3280.123 &.181(c); 3290.123 &.181(c)

NAME OF CHILD		
FEE AMOUNT $	PER-DAY-WEEK	DAY PAYMENT TO BE MADE Monday

Services to be provided as part of the day care fee (examples; transportation, care, meals, etc.)

Colonial Sports School Year Program provides the proper balance of fun, learning, and exercise in a safe and structured environment for children kindergarten through 7th grade. The program includes transportation, homework time, afternoon snack, and outdoor play. Supervision is provided by qualified staff.

CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
LATE FEE $ 1.00	PER MIN-HR per minute	

Extra services to be provided at an additional fee if applicable

I, the parent/guardian;

☐ received complete written program information at the time of enrollment. (§ 3270.121, 3280.121, 3290.121)

☐ agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minumum. (§ 3270.124, 3280.124, 3290.124)

SIGNATURE-OPERATOR DATE

SIGNATURE-PARENT OR GUARDIAN DATE

DATE OF CHILD'S ADMISSION
DATE OF WITHDRAWAL

PERIODIC REVIEW

SIGNATURE-PARENT OR GUARDIAN DATE

EMERGENCY CONTACT / PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124(a)(b), 3270.181 & 182; 3280.124 (a)(b), 3280.181 & .182; 3290.124 (a)(b), 3290.181 & .182

CHILD'S NAME	BIRTHDATE
ADDRESS	
MOTHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	
FATHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	

EMERGENCY CONTACT PERSON(S)	NAME	TELEPHONE NUMBER WHEN CHILD IS IN CARE

PERSON(S) TO WHOM CHILD MAY BE RELEASED	NAME	ADDRESS	TELEPHONE NUMBER WHEN CHILD IS IN CARE

NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER	TELEPHONE NUMBER
ADDRESS	

SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTION)
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICATION, SPECIAL CONDITIONS
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD	
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS	POLICY NUMBER (REQUIRED)

PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT

OBTAINING EMERGENCY MEDICAL CARE	**ADMIN. OF MINOR FIRST - AID PROCEDURES**
WALKS AND TRIPS NOT APPLICABLE	SWIMMING NOT APPLICABLE
TRANSPORTATION BY THE FACILITY	WADING NOT APPLICABLE

PERIODIC REVIEW

SIGNATURE OF PARENT or GUARDIAN _____ DATE _____

SIGNATURE OF PARENT or GUARDIAN _____ DATE _____

PHYSICAL, MEDICAL & DIETARY

Child's Name _____ Person Filling Out Form: _____

If your child has any **physical, medical, dietary** or other special needs, please note them on this form. If these needs require specific care, we need a copy of the script from the doctor's office before your child starts the program**. If this form does not pertain to your child, please write "none".**

1. Please state the nature of the physical, medical, dietary or other special need:

2. Please provide signs/symptoms of the need and the course of action to be taken if symptoms are exhibited:

3. Please list any medications your child takes on a regular basis. If they need to be administered by our staff, please include a doctor's instructions along with the **original container of medication**. Any prescribed medication, including inhalers and EpiPens, **must be turned in prior to the child's first day of attendance**. ***We do not provide ANY medication including Benadryl, Tylenol, etc. and cannot administer ANY medication without a doctor's written instructions.***

4. **Does your child have an IEP (Individual Education Program)? YES NO**
   (Please Note: If Applicable, a copy of the full IEP must be turned in at least 5 days prior to your child's first day of attendance and may require meeting with the staff before care begins.)

Please list any additional information you feel we should know in order to better serve your child.

_____

_____

_____

I give permission for my child to participate and be photographed in any and all activities. I grant permission for the photographs to be used in any CHB Sports, Inc., publication**. YES NO**

_ _

Medical Waiver: We understand that in case of emergency and we are unable to be contacted, we give permission to Colonial Sports to authorize any emergency action necessary to insure the safety of our child. This does not in any way hold CHB Sports, Inc., financially responsible or otherwise liable for any medical or emergency care given. Which hospital do you wish to use if need be?

Hospital: _____ Parent Signature: _____ **Date: _____**

Waiver: I hereby waive and release any and all rights for myself, my heirs, executors, and administrators this enrollee may have against CHB Sports, Inc. or its representatives, agents, and successors for any and all injuries the participant may suffer in connection with his/her participation in any Colonial Sports Programs.

Parent Signature: _____ **Date: _____**

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG) ☐ YES ☐ NO	**NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.**	
	VISION (subjective until age 3)	
	HEARING (subjective until age 4)	
	LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:		TITLE:
	PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.