Admission Date:_____ **Termination Date:_____**

KCC SAFE Afterschool Program 2020-21
Enrollment Form

Please fill out the form completely! Failure to complete all sections of the form will result in delay in processing the application. This includes addresses and phone numbers of doctor, dentist and all contacts. If you select care thru 6:00pm you will be sent separate payment information.

Please select one: Gap Care Dismissal to 3:00pm_____SAFE Care until 6:00pm_____

Child's Name:_____

Please select the school your child is attending: Mitchell_____ Shapleigh_____

Please select the grade your child is in: K____ 1st_____ 2nd_____ 3rd_____ 4th_____ 5th____

Which days of the week will your child be attending?

Monday_____ Tuesday_____ Wednesday_____ Thursday_____ Friday_____

Will your child be arriving by bus transportation or will you be transporting in your own vehicle?

Bus_____ Own Vehicle____

Child's Name:_____ DOB:_____ Age:_____

Address:_____ Town:_____ State:_____

Parent #1:_____ Address:_____

Parent #2:_____ Address:_____

<u>Phone Numbers where parents can be reached during the day:</u>

Parent #1 (H):_____ Parent #1 (W):_____

Parent #1 (Email):_____

Parent #2 (H):_____ Parent #2 (W):_____

Parent #2 (Email):_____

<u>Other method of contact while your child is in our care (i.e. Cell Phone or Pager):</u>

_____

Parent #1's place of employment and address:

_____

Parent #2's place of employment and address:

_____

Persons to contact in case of emergency. **OTHER THAN PARENT OR GUARDIAN Please be sure to include a non-family member contact (neighbor, friend, etc.)**

Contact #1:_____ **Phone #:**_____

Relationship to child:_____ **Address:**_____

Contact #2:_____ **Phone #:**_____

Relationship to child:_____ **Address:**_____

Medical Information:

Doctor's Name:_____ **Phone #:**_____

Address:_____ **Town/State:**_____

Dentist's Name:_____ **Phone #:**_____

Address:_____ **Town/State:**_____

If, in the event of an emergency and your Doctor cannot be reached, we will use Kittery Family Practice of York Hospital.

Which hospital do you use?_____

Any allergies, disabilities, or other medical conditions? _____ If yes, please explain:

_____

Please list any special needs (or any other information) that you would like to share with our staff to help them provide proper care for your child.

_____

<u>Release Information:</u>

Please list anyone who has your permission, including your name and your spouse's/partner's name, to pick up your child from this program. Anyone who is not listed will not be permitted to remove your child from the program.

_____

Please list anyone that does NOT have your permission to pick up your child from this program. Please include their relationship to your child.

_____

KITTERY COMMUNITY CENTER-PARENT RECOGNITION FORM

I, _____have read the SAFE Program Information Packet and understand what
Parent/Guardian Name
is expected of my child, and myself. I am aware of registration fees, program costs, and when payments are due. I understand my child is responsible for his/her own belongings and respecting others. I will inform SAFE staff of any changes in my child's health, or personal information (address, phone #'s, etc.) I understand SAFE staff will do everything in their power to provide my child with the care, respect, and safety I expect throughout the year.

_____ _____

Parent/Guardian Signature Date

RELEASE WAIVER

I hereby give permission for my child to participate in the Kittery Community Center's SAFE Program, including walks to Roger's Park, and special events. I also give permission for my child to be treated by a medical professional in the event of an emergency. I hereby waive, release, and discharge the Kittery Community Center, the Town of Kittery, all Town Employees, and all volunteers from all liability that may arise from any injury to my child.

_____ _____

Parent/Guardian Signature Date

PHOTO RELEASE

_____**I give** _____**I do not give permission** for my child to have his/her picture taken for publication in local newspapers or Community Center program guides.

_____ _____

Parent/Guardian Signature Date

MEDICAL INFORMATION

I hereby give my consent, in the event of a medical emergency when I cannot be contacted, for child care staff to obtain whatever treatment may be deemed necessary for
_____ DOB:_____

Child's Name

This authorization includes my consent for the above-named child to receive treatment by a physician in any hospital Emergency Department. I hereby give my authorization for emergency medical treatment as outlined above.

Known allergies:

Known medical problems:

Last Tetanus shot:

Parent/Guardian Signature:_____ Date:_____