Georgia Department of Human Services
Afterschool Care Program
Participant Forms
2017 – 2018

Note: The program can use its own internal Registration Form. If a program does not have their own internal Registration Form, they are to use the Registration Form provided.

DFCS Afterschool Care Program Registration Form

Entrance Date: ________/________/________ Withdrawal Date:________/________/________

SECTION I: CHILD'S PERSONAL INFORMATION

Legal Last Name	Legal First Name	Legal Middle Name

Date of Birth (MM/DD/YYYY) ___ ___/___ ___/___ ___ ___ ___ Age _________

Gender ___Male ___ Female ____ Other _______________

Home Address P.O. Box/Apt #		
City:	State:	Zip Code:
Home Phone Number		
Alternate Phone Number		

SECTION II: CHILD'S SCHOOL INFORMATION

Grade Level: (upcoming school term)	School Attending:

Is the student an ESOL* student: ____ Yes ____ No

** English as a second language*

SECTION II: CHILD'S DEMOGRAPHICS INFORMATION

Ethnicity

___ Black, Non-Hispanic ___Hawaiian Native/Pacific Islander

___ White, Non-Hispanic ___Alaska Native/American Indian

___Asian ___Hispanic/Latino

Other - Specify: _________________________________

Is the student a special needs student? ____ Yes ____ No

If yes, please specify the child's special need(s):

SECTION IV: CHILD'S HOUSEHOLD INFORMATION

Participant Lives With:

____ One parent

____ Both parents

____ Guardian/Caregiver

____ Grandparents

____ Foster Home

____ Group Home

____ Other

How many people are in your household? ______________________________

SECTION V: PARENT/GUARDIAN DECLARATORY STATEMENT

I (print name) ____________________________ certify that all the information given in this form is correct and true to the best of my knowledge. I understand that providing false information may result in my child not being able to participate in the afterschool care program.

____ ______________________________

Parent or Guardian Signature Date

Georgia Division of Family and Children Services
Afterschool Program
Parental Permission for Photo Release

Page two of this document requests your permission for the Division of Family and Children Services (DFCS) to take and use photographs of your child and other Afterschool Care Program staff. When we tell others the story about the DFCS Afterschool Care Program, it would be helpful to share photographs of the statewide participants. Pictures can enhance people's understanding about who is involved in the program and what activities and services are being conducted. If you have more than one child, this form should be completed for each child participating in the DFCS funded afterschool program.

If you agree for us to take and use these photographs, our use of them will include, but will not necessarily be limited to the following: publications about the program; recruitment activities to reach additional youth who might participate in the future; and/or reports about the program to supporters and others who are interested in the program's outcomes.

If you have any questions regarding the Photo Release Form, please contact the DFCS Afterschool Care Program at 404-657-4651.

Photo/Video Release Agreement

DeKalb County, Georgia
School/Organization Name: Whitefoord, Inc.

1. I, the undersigned, consent and agree that still photographs, motion pictures, or television presentations in the form of either live or video tape may be made of myself, my child (ren) by the Georgia Department of Human Services.
2. This release gives the Georgia Department of Human Services the right to use the above-listed visual material in conjunction with the teaching, instruction, training, information and education of employees of the Department or the general public.
3. Further, I hereby release the Georgia Department of Human Services and forever discharge any claim of any nature against them as long as the material is used in compliance with the above-stated paragraph 2.
4. I grant this consent as (parent-guardian) a voluntary contribution in the interest of the said reasons listed in paragraph 2.
5. I understand this Photo/Video Release Agreement does not apply to children in foster care. I further understand if my child is in the foster care system within Georgia, they are not allowed to be photographed or included in motion pictures or television.

Parent/Guardian Name ____

Parent/Guardian Address ____

____

Parent/Guardian Telephone _______________

Photo Description: **<u>Participation in the DFCS funded afterschool program activities.</u>**

Children Participating in Program:

Name ____ Age __________

____ __________

____ __________

Parent/Guardian Signature _____________________________________ Date ________

Photographer or producer or witness: ____

Afterschool Program

Participant Medical Information Form – Page 1

(To be maintained on site for each participant)

STUDENT INFORMATION

Legal Name of Child *(Last, First):* | Date of Birth *(MM/DD/YYYY)*: | Age: | Sex *(check one):* ❑ Male ❑ Female

Street Address: | Home Phone No:

P.O. Box/Apt #: | City: | State: | Zip Code:

INSURANCE INFORMATION

Does the child have health insurance coverage?
❑ Yes ❑ No

Name of insurance provider (if applicable):

Child's doctor or clinic name:

Doctor /clinic Phone Number:

MEDICAL INFORMATION

Does the child have any allergies? ❑ Yes ❑ No
If yes, please list them:

Does the child have any other medical conditions (disabilities, infections, viruses, diseases, etc)? ❑ Yes ❑ No
If yes, please list them:

Is the child currently taking any medications (prescribed and non-prescribed)? ❑ Yes ❑ No
If yes, please list them:

The following special accommodation(s) may be required to most effectively meet my child's needs while at the center:

IN CASE OF EMERGENCY

Contact Name: | Relationship to youth: | Home Phone Number: | Work Phone Number:

Alternate Contact Name: | Relationship to youth: | Home Phone Number: | Work Phone Number:

Participant Medical Information Form – Page 2

By signing below, I certify the above information is true to the best of my knowledge. I authorize Whitefoord, Inc. to contact me if my child is injured and/or harmed in any way. I also authorize Whitefoord, Inc. to seek medical attention for my child if he or she is injured and/or harmed and needs immediate medical assistance at a local hospital or emergency care center. I certify that I and/or our family's insurance provider will be responsible for any financial medical costs that may be associated with all medical attention and treatment given to my child. In consideration of their granting my child the opportunity to participate in the Afterschool Care Program, I hereby release, indemnify and hold harmless the Department of Human Services and Whitefoord, Inc. from any liability, claim or demand resulting from any legal medical attention and assistance that may be needed and provided as a result of an injury or harmful incident to my child.

______________________________	______________________________	______________
Legal Name of Parent (print)	Parent Signature	Date

Facility Administrator/Person-In-Charge______________________________ ______________

Signature Date

GEORGIA DEPARTMENT OF FAMILY & CHILDREN SERVICES
AFTERSCHOOL CARE PROGRAM

Field Trip Declaration Form FFY 2018

Name of Organization: **Whitefoord, Inc.** ____________________

Address of Organization: **1353 George Brumley Way, Atlanta, Georgia 30317**

Contact Phone Number for Organization: **678 488-4146/ 404 523-2500** ____________

Declaration Statement

By signing below, I understand the youth who participate in the Whitefoord, Inc. afterschool/summer program may participate in various field trips throughout the contract period from 10/30/2017 ending 09/30/2018 funded by the DFCS Afterschool Care Program. In consideration of the youth for the opportunity to participate in field trips, Whitefoord, Inc. hereby releases, indemnify and hold harmless the Georgia Department of Human Services from any liability, claim or demand resulting from such participation. I understand I am to mail a signed copy of this form to the DFCS Afterschool Care Program at the address provided below. I further understand this form must also be kept on file at the afterschool/summer site indicated above at all times.

Georgia Division of Family &and Children Services
Afterschool Care Program
2 Peachtree Street, NW
26th Floor
Atlanta, Ga 30303

…………………………………………………………… ………………/………………/……………………
Signature of Parent/Guardian **Date**

____________________________________ ____________________ __________

Printed Legal Name of Authorized Staff **Title** **Date**

____
Signature of Authorized Staff

Georgia Division of Family and Children Services
Community Programs Unit
Afterschool Care Program
Youth Participation Eligibility Form

MCLBA Child and Youth Programs and the Georgia Division of Family and Children Services (DFCS) are partnering to provide valuable out-of-school programs for youth in Georgia. The information provided on this form will help ensure that eligible youth are benefiting from the partnership. **Please complete this form in its entirety and return it to the identified staff person at the program site. We thank you for your cooperation.**

Form to be completed by Parent/Custodian/Caregiver

Youth Information – ***This section must be completed in its entirety.***

Name of Youth Participant (Last)____________________________ (First)____________________________(MI) ______

Social Security Number________-________-_ Date of Gender:________Male_________Female

Birth (mm/dd/yy):_______________/_______/_______

Is the youth named above in Foster Care within the state of Georgia ☐ Yes ☐ No
Note: If the youth is in Foster Care but not in the care of Georgia, please provide the state name ______________________________

Section 1

A. Is the youth applicant a U.S. citizen or qualified alien? ☐ Yes ☐ No
B. Is the youth applicant a Georgia resident? ☐ Yes ☐ No
C. Does the youth applicant fall into one (1) or more of the three categories below (Answer YES or NO and check all categories below that apply to the youth)?: ☐ Yes ☐ No
____Youth applicant is between the age of 5 and 17 years old; **OR**
____Youth applicant is 18 years old and currently enrolled in school *(high school, GED program or equivalent, or post secondary institution)* and will be enrolled in AND attend school during the upcoming academic year *(Verification of school enrollment includes a letter from the school on official school letterhead):* **OR**
____Youth applicant is 18 - 19 years old and has a dependent child AND is the custodial parent

If the one (1) or more answers to the questions in Section 1 is NO, the youth **IS NOT** eligible to participate in the DFCS funded services. **If the answer to ALL of the questions in Section 1 is YES**, please complete the remainder of the form.

Section 2

Does the youth currently receive benefits or services under any of the programs listed below (Please Note: you will have to provide official verification to the afterschool/summer program):

		Yes	No
A.	Temporary Assistance for Needy Families (TANF)	☐	☐
B.	Supplemental Nutrition Assistance Program (SNAP) *(also known as Food Stamps)*	☐	☐
C.	Medicaid or Social Security Income (SSI)	☐	☐
D.	Reduced or free lunch program at school – *Note: This eligibility is only for single youth eligibility. Please do not utilize the universal school eligibility.*	☐	☐
E.	Peachcare for Kids	☐	☐

If the answer to at least one question in section 2 is YES, the youth is eligible to participate in the program and the parent/custodian/guardian may complete Section 5. Verification for receipt of services checked in Section 2 must be provided and a copy of the verification must be attached to this eligibility form. If the program does not receive verification of items checked in Section 2, the youth will not be able to participate in the program.

If the answer to ALL of the questions in Section 2 is NO, the parent/custodian/guardian **MUST** complete Section 3, Section 4 and Section 5 for eligibility determination. Verification for items listed in Section 3 and Section 4 must be provided and a copy of the verification must be attached to this eligibility form.

Section 3

If you answered NO to ALL of the questions in Section 2, please review the chart below and enter your family unit size, gross household yearly income and gross household monthly income to determine eligibility.

Family Income Eligibility for the DFCS Afterschool Care Program Income Eligibility Guide

Number of Persons in Family Unit	Federal Poverty Level *	DFCS Afterschool Care Program Annual Household Income Guidelines **	DFCS Afterschool Care Program Monthly Household Income Guidelines
1	$11,770	$35,310	$2,943
2	15,930	$47,790	$3,983
3	20,090	$60,270	$5,023
4	24,250	$72,750	$6,053
5	28,410	$85,230	$7,103
6	32,570	$97,710	$8,143
7	36,730	$110,190	$9,183
8	40,890	$122,670	$10,223
Each additional person, add	$4,160	$12,480	$1,040

* Income based on the Office of the Secretary, U.S. Department of Health and Human Services (HHS) 2014 Poverty Guidelines for the 48 Contiguous States and the District of Columbia. (Source: 80 FR 3236, Page 3236 – 3237, Document Number: 2015-01120)
** 300 % of the federal poverty level. Released January 22, 2015.

Family Unit Size* _____
Gross Household Yearly Income $______________ Gross Household Monthly Income $_______________

** See Appendix A for definition of family unit.*

Section 4

Please complete Section 4 by listing your name, the name of the child (ren) who live with you, and the other parent of the child (ren) if s/he lives with you. List any gross monthly income for each.

Household Composition and Income

Gross Monthly Income is income before taxes and deductions.

Name (First, Middle, and Last)	Relationship	Date of Birth (MM/DD/YY)	Income Source	Amount (Gross Monthly Income)	How often received?
	SELF				

Section 5

Please review and sign Section 5 as notification and signature of verification.

Applicant Notification and Signature

We are asking for your youth's Social Security number because any person applying for or receiving federal benefits must give us his or her Social Security number. Federal law 409(a) (4) of the Social Security Act and federal regulations (45 CFR 264.10) allow us to collect this information.

By signing this application,

- I swear, under penalty of perjury, that to the best of my knowledge, all the information and statements I've provided in this application are true, and
- I promise to cooperate with any effort to verify the information provided.
- If selected to participate in the program, I promise to abide by all rules and guidelines.

Parent/Guardian/Caregiver Information – ***This section must be completed in its entirety.***

Name of Parent/Guardian/Caregiver (Last, First, MI) ______________________________

Street Address______________________City__________State______Zip Code ______

Home Phone #______________Work #______________Cell# ______________

______________________________ ____________
Parent/Caregiver/Guardian Printed Name Date

______________________________ ____________
Parent/Caregiver/Guardian Signature Date

To be Completed by DFCS Funded Afterschool/Summer Service Provider

By signing below, I certify the information presented within this form was reviewed, verified and confirmed** and meets the DFCS Afterschool Care Program Eligibility rules and guidelines indicated within this form. I also certify this form will be kept in the youth participant's file in a confidential and secured location.

______________________________ ______________ ____________
Authorized Program Staff Signature Title Date

***** See Appendix B for income verification proof sources***

Page 1 of 2 - DFCS Afterschool Care Program Eligibility Form Appendix

APPENDICES

***Appendix A: Family Unit**

The Department of Human Services Temporary Assistance for Needy Families (TANF) definition of family includes the dependent child for whom assistance is requested and certain other individuals living in the home with the child who are required to be included in the family.

The following individuals are considered members of the Family Unit:

- A biological or adoptive parent of the dependent child for whom assistance is requested;
- An eligible minor sibling, (whole, half or adoptive) of the dependent child for whom assistance is requested;
- Other children living in the home who are within the specified degree of relationship to the grantee relative but who are not members of the Family Unit; and
- A non-parent relative who is the caretaker if there is no parent in the home or if the only parent in the home receives SSI.
- An individual documented as the youth's caregiver. A caregiver is considered a person who provides direct care to the youth. This provision includes foster parents.

****Appendix B: Income Proof Sources and Applicable Income Sources**

Income verification must be obtained and a copy must be attached to the youth's income eligibility form.

Examples of earned income verification are:
- Pay stubs or receipts for the most recent four weeks of earnings;
- W-2 Forms;
- Employer's issued, signed and dated documentation;
- Personal income ledger or tablet (e.g. self-employed)
- Quarterly income tax returns;
- Annual income tax returns when presented in January – March quarter;
- Letter/statement from employer;
- Documentation from other DFCS staff such as the eligibility CM; and/or
- Form 809 or itemized statement completed by the employer.

Examples of unearned income verification are:
- Copy of current check with check stubs (within last 4 weeks);
- Award letters or written, signed and dated statement of payer;
- Social Security Records;
- Worker's compensation records;
- Form 139 – Contribution statement;
- Unemployment insurance claim records;
- SUCCESS screen information; and/or
- STARS.

See page 2 of Appendix B for applicable income sources.

Page 2 of 2 - DFCS Afterschool Care Program Eligibility Form Appendix

Applicable Income

Each of the following sources of income is budgeted in determining eligibility:

Earned

- Wages or salary – Gross income of the applicant is used to determine eligibility
- Net Income from Self-Employment
- Employee commission
- Jury Duty
- Rental Income – (regular and ongoing payments – if engaged in management of property for an average of 20 hours or more per week)
- Roomer Income – (regular and ongoing payments)

Unearned

- Military Allotments
- Cash gifts Charitable gift exceeding $300 received from and organization receiving state or federal funds
- Inheritances
- Insurance Benefits due to Loss of Income – benefits paid from an insurance policy due to loss of income
- Social Security Benefits
- Unemployment Compensation
- Worker's Compensation
- Alimony – (regular and ongoing payments)
- Child Support – (regular and ongoing payments)
- Farm Allotment – payments received from government-sponsored programs, such as Agricultural Stabilization and Conservation Services
- Veteran's Benefits
- Capital Gains
- Interest/Annuity
- Capital Gains/Dividends
- Pension
- Trust Fund
- Disability Payment
- Boarder Income – (regular and ongoing payments)
- Rental Income – (regular and ongoing payments - if engaged in management of property for an average of 20 hours or less per week)
- Deferred compensation through retirement plan

****Appendix C: Acceptable Verification of Benefits or Services**

- **Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Medicaid, PeachCare** : Official documentation showing the family/youth is currently receiving benefits at the time of application/enrollment into the afterschool care program (COMPASS documentation, SUCCESS documentation, Official Letter from the Georgia Division of Family and Children Services outlining the receipt of benefits).
- **Supplemental Security Income (SSI) :** Award letter from the Social Security Administration
- **Free or Reduced Lunch :** Award letter identifying free or reduced lunch as established by individual family eligibility. Note: Programs may receive a listing of students receiving free or reduced lunch granted the listing is on official school letterhead with the disclaimer that all free or reduced lunch eligibility is determined by individual family application. Universal, school- wide, city-wide or district-wide free lunch does not qualify as an acceptable point of eligibility for the DFCS Afterschool Care Program.

Whitefoord School Based Health Center Consent Form

Whitefoord, Inc.
Uniting Community through Health and Education

Thank you for allowing Whitefoord School-Based Health Centers to serve you. Please complete this consent form and provide proper documentation of insurance in order to receive services for your child.

I hereby give my consent for ____ to receive comprehensive health services at Whitefoord School-Based Health Centers. I further authorize any health professional working for Whitefoord School-Based Health Centers to provide medical tests, procedures, and treatments that are necessary or advisable for the medical evaluation and management of my child's health care. Furthermore, I agree to actively participate in the primary health care of my child by accompanying him/her to Whitefoord School-Based Health Center appointments and attending educational programs developed for parents/guardians when possible. **I also understand that I have the right to withdraw this consent at any time upon written notice to the center director.**

I authorize:

- Release of information from my child's medical record whenever necessary for care including referrals and/or emergency services.
- Release of written and verbal information important to my child's health care from the staff of Whitefoord School-Based Health Centers whenever necessary for his or her care. I further give consent for the staff to examine my child's full school record, including attendance and other information that may assist the staff in helping my son/daughter to accomplish the purposes described above.
- Release of information regarding treatment to third party payers such as Medicaid and other insurers for the purposes of billing and any other reason in accordance with acceptable medical practice laws. Charges for services rendered to uninsured and HMO insured patients who choose to use our services out of network will be based on a sliding fee scale. ***No student will be denied services because of inability to pay.***
- Permission to disclose protected health information about my child for the purposes of payment, continued care or treatment, and healthcare operations, including any records containing information related to the treatment of infectious diseases (including AIDS), drug or alcohol abuse and/or mental illness.
- Periodic dental examinations for my child, which may include screenings, photographs, radiographs, and any other acceptable methods for the dental evaluation and management of my child's dental health.
- HIV testing upon request of student or as deemed necessary by the provider.
- Participation in the Fitness Program sponsored/coordinated by Whitefoord Inc. Health Education Department.
- Vaccination for state required and recommended immunizations according to ACIP and CDC guidelines including HPV and influenza (flu shot).

Benefits of Whitefoord School-Based Health Centers:

- Increased school attendance
- Enhanced academic performance
- Improved attitude and behavior
- Reduced time lost from work
- Creates a more cost-effective approach to healthcare

I have read and understand the above information and give permission for my child's care as described. *I understand that I have the right to OPT-OUT of any medical testing or treatment.* I also understand that I may obtain further information regarding the health services offered by the Centers by contacting the Whitefoord Health Center at (404) 588-0101.

<table>
<tr><td>Name of Parent or Legal Guardian (please print):</td><td colspan="2">Name of Student (please print):</td></tr>
<tr><td>Signature of Parent or Legal Guardian:</td><td>Relationship to Student:</td><td>Date:</td></tr>
</table>

PATIENT INFORMATION

Whitefoord, Inc.
Uniting Community through Health and Education

Full Legal Name: ____________________ **Date of Birth:** ____________
Street Address/ Apt #: ____________ **County:** ________ **City:** ________ **Zip:** ______
Is Present Housing: ☐ Rent ☐ Own ☐ Temporary ☐ Shelter ☐ Group Home/ Foster Care ☐ Homeless ☐ Other: ________
Sex: ☐ Male ☐ Female **Social Security Number:** ____________ **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic
Race: ☐ Unknown ☐ American Indian ☐ Pacific Island ☐ Alaskan Native ☐ Black ☐ Asian ☐ White ☐ Other: ________
Patient's Primary Language: ________ **Does patient qualify for free/reduced lunch?** ☐ Yes ☐ No **IEP/504 Plan:** ☐ Yes ☐ No
School Patient Attends: ____________ **Grade:** ____ **Home School:** ☐ Yes ☐ No **Remedial/Special Ed:** ☐ Yes ☐ No
Student's Cell Phone #: ____________ **Student's Email Address:** ____________

INSURANCE AND PROVIDER INFORMATION (All fields required)

Does the patient have medical insurance?: ☐ Yes ☐ No If yes, what type of insurance?: ☐ Medicaid ☐ Private ☐ Other: ________
If Medicaid: Medicaid ID #: ____________
If Private Insurance: Company Name: ____________ Policy Holder Name: ____________
Policy #: ____________ Group #: ____________
Does the patient have dental insurance? ☐ Yes ☐ No *If yes, please fill out the following:*
Company Name: ____________ Policy Holder Name: ____________
Policy #: ____________ Group #: ____________
Does the patient have a Primary Care Physician (PCP)? ☐ Yes ☐ No *If yes,* PCP name/phone #: ____________
Does the patient have a Dentist? ☐ Yes ☐ No *If yes,* Dentist name/phone #: ____________
Would you like to make Whitefoord Inc. School-Based Health Centers the patient's PCP? ☐ Yes ☐ No

PARENT/ GUARDIAN INFORMATION

Name: ____________ **Relationship to Patient:** ________ **DOB:** ________
Street Address/Apt # (If different from above): ____________ **City:** ________ **Zip:** ______
I agree that messages can be left from me on: ☐ Home Phone ☐ Cell Phone ☐ Work Phone
Preferred Phone Number: ____________ **Email Address:** ____________
Is either parent/guardian a Military Veteran?: ☐ Yes ☐ No **Is either parent/guardian incarcerated or deceased?:** ☐ Yes ☐ No
What is the financially responsible party's household size? ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐More If more, how many?: ___
What is the financially responsible party's monthly estimated household income? ____________

EMERGENCY CONTACT (if different than Parent/Guardian):

Name: ____________ **Relationship to Patient:** ________ **Phone #:** ____________

STUDENT MEDICAL HISTORY

MEDICAL HISTORY

Does the patient take any medications? *List all medications:*	☐ Yes ☐ No	
Does child need to take prescribed medications during school hours? *List all medications:*	☐ Yes ☐ No	
When was the patient's last well check visit?		Date:
Has the patient had any surgery in the past?	☐ Yes ☐ No	Explain:
Has the patient had any shunts placed or has an indwelling catheter?	☐ Yes ☐ No	Explain:
Has the patient started their period?	☐ Yes ☐ No	Start date:
Is/was the patient a teen parent?	☐ Yes ☐ No	
Is the patient pregnant or possibly pregnant?	☐ Yes ☐ No	Due date:
Is the patient currently nursing?	☐ Yes ☐ No	
Is premedication with antibiotics needed prior to dental procedures?	☐ Yes ☐ No	Explain:

DOES THE PATIENT HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS?

Condition	Yes / No	Condition	Yes / No
Anemia	☐ Yes ☐ No	HIV/AIDS	☐ Yes ☐ No
Abdominal Pain	☐ Yes ☐ No	Kidney/Urinary Tract Problems	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	Learning/development issues	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Lung Problems	☐ Yes ☐ No
Autism	☐ Yes ☐ No	Meningitis	☐ Yes ☐ No
Bladder or kidney infections	☐ Yes ☐ No	Menstrual problems	☐ Yes ☐ No
Blood Disorder	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No
Broken Bones/Major Injuries	☐ Yes ☐ No	Overweight/obesity	☐ Yes ☐ No
Cancer/leukemia	☐ Yes ☐ No	Physical/Sexual abuse	☐ Yes ☐ No
Chicken pox	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No
Constipation/Diarrhea	☐ Yes ☐ No	Premature birth weight:	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Respiratory/ Breathing problems	☐ Yes ☐ No
Ear infection/problem	☐ Yes ☐ No	Rheumatic fever, heart disease, murmur	☐ Yes ☐ No
Eating issues	☐ Yes ☐ No	Scoliosis	☐ Yes ☐ No
Endocrine/gland disease/autoimmune disease	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Eye problem	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Fainting spells	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Frequent colds	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Frequent sore throat	☐ Yes ☐ No	Thyroid disease	☐ Yes ☐ No
Headaches/migraines	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Hepatitis or liver problems	☐ Yes ☐ No	Ulcer/digestive problem	☐ Yes ☐ No
High blood pressure	☐ Yes ☐ No	Underweight	☐ Yes ☐ No
		Other:	

ALLERGIES

Any foods (including lactose intolerance)	☐ Yes ☐ No	Comment:
Any medications (including over the counter or antibiotics; penicillin or amoxicillin)	☐ Yes ☐ No	Comment:
Local anesthetics (including lidocaine) or latex	☐ Yes ☐ No	Comment:
Does the patient have an Epi-Pen at school?	☐ Yes ☐ No	Comment:
Other:		

DENTAL HEALTH

Any problems with teeth?	☐ Yes ☐ No
Any teeth causing pain?	☐ Yes ☐ No
Any bleeding when brushing or flossing?	☐ Yes ☐ No
Had a dental cleaning within the last 6 months?	☐ Yes ☐ No
How often does patient brush teeth?	Comment:

BEHAVIORAL HEALTH: Please complete ONLY if patient is in need of behavioral health services

Would you like to enroll the patient in behavioral health services?	☐ Yes ☐ No
Has the patient ever had counseling services?	☐ Yes ☐ No

Has the patient ever had any of the following?:

Alcohol abuse issues	☐ Yes ☐ No	Eating disorder	☐ Yes ☐ No	Shy	☐ Yes ☐ No
Anger issues	☐ Yes ☐ No	Family Changes	☐ Yes ☐ No	Sleeping problems	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No	Learning disabilities	☐ Yes ☐ No	Slow development	☐ Yes ☐ No
Attention difficulties	☐ Yes ☐ No	Overactive/Hyperactive	☐ Yes ☐ No	Social/peer stresses	☐ Yes ☐ No
Bedwetting	☐ Yes ☐ No	Recent Loss	☐ Yes ☐ No	Other Problems	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Mood swings	☐ Yes ☐ No		
Drug use	☐ Yes ☐ No	School/Discipline issues	☐ Yes ☐ No		

If answered yes to any of the above, please comment:

FAMILY HISTORY: Please specify who in your family has or had any disease listed below. LEAVE BLANK IF NOT APPLICABLE.

Allergies:	High Blood Pressure:
Asthma:	Kidney/Bladder Problems:
Birth Defects:	Lung Disease:
Blood Disorders/Anemia:	Mental Illness:
Cancer:	Muscle Disease/Weakness:
Cystic Fibrosis:	Seizures:
Death under Age 50:	Tuberculosis:
Diabetes:	Tumors:
Ear/Eye Disorders:	Other:
Early Childhood Death:	
Heart Problems:	

THE WHITEFOORD INC. BEYOND SCHOOL HOURS PROGRAM RELEASE INFORMATION

Student's Name: ____

Children are not allowed to leave the Whitefoord Inc. Beyond School Hours Program without being escorted by their parent or legal guardian. In the event that the parent or legal guardian is not available, children must be escorted by one of the individuals listed on this form. **We cannot accept additions or deletions to this form by telephone or fax.** All changes must be made by the parent or legal guardian **with the Administrator of Program**. All designated individuals listed below **must be eighteen years of age or older.** Until the staff of the center becomes familiar with all of the individuals on this form, they will request picture identification. This is for your child's safety. **We will not dismiss children to any other individuals.**

Please list adults other than yourself to whom your child may be released: (**Please print**)

Name: ____ Phone (   ) ___________________

Relationship to child: ________________________________

Address: ____

Name: ____ Phone (   )___________________

Relationship to child: _______________________________

Address: ____

I understand that if my child remains at the Beyond School Hours program past the scheduled closing time, I will be required to have a conference with the Program Director.

Parent/Legal Guardian's Signature: ____

Parent/Legal Guardian's Daytime Phone number: (   ) _______-_______   Date ____________

Email address____

Please use other side if necessary

2017/18 BEYOND SCHOOL HOURS FEE AGREEMENT

This fee agreement is for the following child:

____

After reviewing your household income statement and based on our criteria, your weekly child care fee per week is$____________.

PAYMENTS DUE
Payment is due on Friday for the upcoming week. Payment is late on Monday after 9a.m. Payments are to be placed in the locked box on the office door of the Infant/Toddler house. Do not give payments to staff or leave them in book bags.

LATE PICK UP FEES
Late pick up fees are $1.00 per minute and will be applied to the account and payable with the following week's payment.

FORM OF PAYMENT
Payments are accepted via check and money order in the drop box. Make checks and money orders payable to MERG. We are offer the convenience of Tuition Express for ACH check and credit card payments. Tuition Express accepts American Express, Discover, MasterCard and Visa. Childcare and Parent Services (CAPS) payments are also accepted.

RETURNED CHECKS
A fee of $35 will be assessed for any returned payment.

SICK POLICY

A. Full payment is expected for child/children who are out sick any day in any given week.
B. One free week per school year will be considered for a child who has been absent for a full week to illness.

A written doctor's note with documented dates of care and approval by Program Director is required before sick week can be credited.

HOLIDAYS
Full payments are expected for the weeks that include week day holidays such as Thanksgiving, Christmas, New Year's etc.

SLOTS
Space cannot be held for a child who is absent without notice for more than one week. Full payment is expected for a slot that is being held for any reason. To avoid being charged for unused slot, please communicate your intention of withdrawal to administrative staff two weeks prior to withdrawing.

_________________________ _____________ _________________________

Parent/Legal Guardian Date Program Director Date

_________________________ _____________

Administrative Assistant Date