2017-18 JCPRD OST REGISTRATION (Broken Arrow, Merriam Park, Rising Star, Shawanoe)

Participant's Name	Date of Birth
School Location	**Start Date**
Payment Options (Check One)	**Barcode**
Charge Full Tuition ☐ Charge Bi-Weekly Installments ☐	Office Use Only

Days of Attendance (Check Days) **Days must be consistent**
Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐
CARE OPTIONS
Before School ☐ After School ☐
Eligible for Multiple Child Discount?
No ☐ *Yes ☐* *Name of Other Sibling(s)* _____

Enrollment Instructions

Enrollment Accepted by JCPRD
Signature _____
Date _____

1. *Submit Signed and Completed Forms* (6 pages) to JCPRD prior to starting care:
   - Scan & E-mail to Registration@jocogov.org, OR...
   - Mail or Walk-in to Antioch Park: 6501 Antioch Road, Merriam, Kansas 66202
2. You will receive a confirmation email within 2-3 business days, stating that your registration has been processed. If you have not received an email after 3 business days, and have verified that the email did not go to your spam folder, please call our Registration office (913-831-3359) to verify enrollment.
3. You will receive an email prior to August 1st with additional instructions for payment and registration fee submission.

2017-18 OST Fee Installments
(paid bi-weekly, in advance of care)

Care Option	Full Time (4-5 Days/Week)		Part Time (3 Days or Less/Week)		Registration Fee (Due upon Step 3 above)
	1st Child	2nd Child	1st Child	2nd Child	
Before School Only	$56.00	$48.00	$52.00	$42.00	$25.00
After School Only	$118.00	$100.00	$98.00	$84.00	$25.00
Before & After School	$130.00	$126.00	$112.00	$94.00	$25.00
Reduced Lunch - Before & After	$90.00	$90.00	$90.00	$90.00	$25.00
Free Lunch – Before & After	$60.00	$60.00	$60.00	$60.00	$25.00

- All fees are non-refundable and non-transferrable. • ALL required forms must be submitted prior to starting care. • Fees are not prorated.
- Part Time days must be consistent • 2nd Child Discount applies to sibling with lowest fee. • $25 Registration Fee is due upon completion of Registration. •A $15 Fee will be assessed for changes in program options •Families are responsible for reviewing the School Age Care Handbook at www.jcprdkids.com for additional policies, procedures, and terms of enrollment.

JCPRD Authorization Form for Recurring Children's Services Program Payments

JCPRD Authorization Form for Recurring Children's Services Program Payments

I understand that I must call the JCPRD Registration office at the phone number listed below and provide my debit or credit card information to complete this authorization for recurring payments within two business days of receiving confirmation of my registration. Completion of this form will authorize regularly scheduled charges to your Visa, Mastercard, Discover, ***or bank account (via ACH)*** . Your account will be charged per the payment schedule provided by the JCPRD Registration Office. Proof of payment will be available to you through your CLASS registration account. The authority you give to charge your account will remain in effect until JCPRD Registration is notified in writing to terminate this authorization and a new account number is provided to complete your payment schedule, or until fees are paid in full and/or care is terminated. To grant authorization for recurring program payments, complete this form and return it with the remaining registration forms to registration@jocogov.org. For ACH payments, please submit a voided check with this form.

I, _____ authorize JCPRD to charge my account for payment of the JCPRD Program for my child(ren) listed below. I agree to notify JCPRD in writing of any changes in my account information 15 days prior to the next due date of the charges and will not dispute merchant recurring billing with my credit card company, so long as the amount corresponds to the terms indicated in the payment schedule. If my account does not accept the scheduled charges, I am aware that I will be assessed a $30 reconciliation fee, with a maximum non-resolution period of 10 days at which time my child care will be terminated.

X Signature _____ Date _____

Printed Name _____ Email Address _____

Names of All Children Enrolled: _____

***JCPRD** is committed to making reasonable accommodations as required by the **Americans With Disabilities Act.** Requests must be made two weeks or ten working days prior to the start of the program. Please indicate what accommodations are needed:*

JCPRD WAIVER STATEMENT: "The undersigned states that he/she understands that the Johnson County Park and Recreation District is not and shall not be responsible for or liable for any illness, or injury to person or damage to property resulting from the program in which the undersigned is enrolling or being enrolled or from his/her participating in said program, and the participant and the undersigned, if the participant is a minor or under other legal disability, hereby forever releases and holds harmless the said Johnson County Park and Recreation District, it's employees, agents and representatives from any and all claims of any kind that the participant, or the undersigned or their respective heirs, executors, administrators, or assigns may have or claim to have resulting from participation in said program. **NOTICE:** By enrolling in this program you hereby acknowledge the Johnson County Park and Recreation District can and may photograph and/or video tape program participants and then use such images, without payment or any other consideration, for purposes of publicizing District parks, facilities, programs or services, or for any other lawful purpose.

I HAVE READ & UNDERSTAND THE WAIVER STATEMENT & CANCELLATION POLICIES :

X Parent/Guardian Signature _____ **Date** _____

***REGISTRATION IS INVALID WITHOUT SIGNATURE**

SCHOOL DISTRICT WAIVER: We, the undersigned, parents of _____ , acknowledge that the School Age Child Care Program operated by Johnson County Park and Recreation District ("Park District") is not a program operated or controlled by Shawnee Mission School District, Johnson County, State of Kansas (the "School District"); that the School District is only a lessor of space and has no responsibility whatsoever for the administration or operation of the program, for the selection of any employees to operate the program by the provider thereof, or for any act or omission which may occur while any child is going to, participating in, or going from the program. We, further, acknowledge that the program has not been approved by the School District and will not be supervised by the School District. We agree that the School District shall not be liable for any act or failure to act on the part of the Park District, its agents or employees, and we do waive any liability of the School District with reference thereto and promise and agree to save, and hold the School District free and harmless from any and all loss, of any and all nature or kind whatsoever, as the same may relate to any injury suffered or damage sustained by our child(ren) participating in the program or by us.

I HAVE READ & UNDERSTAND THE WAIVER STATEMENT:

X Parent/Guardian Signature _____ **Date** _____

***REGISTRATION IS INVALID WITHOUT SIGNATURE**

Parent/Guardian Name: _____ ( ) _____ ( ) _____

PLEASE PRINT — Day Phone # — Evening Phone #

Address: _____

Street — (Apt. #) — City — State — Zip — (Required)

Please print or type and complete one Personal Data Form for each child enrolled

JOHNSON COUNTY PARK AND RECREATION DISTRICT
2017-18 PERSONAL DATA FORM

School/Program Name: _____

Child's Name: _____ Age: _____ T-Shirt Size: _____

Grade (2017-18)_____ Birth Date: _____

Address: _____
(Street) (City) (State/Zip)

Parent Name: _____ Home#:
Relationship to Child: _____ Work # & Ext. _____
E-Mail _____ Cell # _____

Parent Name: _____ Home # _____
Relationship to Child: _____ Work # & Ext. _____
E-Mail _____ Cell # _____
Emergency contact: _____ Phone #:_____
Relationship: _____
_____ Phone _____
Relationship: _____

Doctor's Name:_____ Phone #:_____

Emergency Hospital Preference: _____

List Food/Substance Allergies:_____

Is child taking Prescription drugs, specify? _____

Will drugs be administered during care hours, specify?_____

The OST program is authorized to release my child to the following individuals without advance written or verbal permission:

Name:_____Relationship: _____ Phone #:_____
Name:_____Relationship: _____ Phone #:_____
Name:_____Relationship: _____ Phone #:_____

(MUST HAVE PHOTO ID TO PICK UP CHILDREN)

Is there special information that would be helpful in meeting the needs of your child? _____

Specifically state any physical limitations: _____

Please state goals for your child's participation in this program: _____

Will your child be leaving the program for lessons, clubs, etc.? (Please state days and arrangements) _____

List special programs, skills or activities you would like to have introduced in the program _____

X Signature of Parent/Guardian:_____ **Date:** _____

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Rev. 1/2014

Kansas Department of Health and Environment
Bureau of Family Health
Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: (785) 296-1270 Fax (785) 296-0803
Website: www.kdheks.gov/kidsnet

HEALTH HISTORY FOR CHILDREN AND YOUTH ATTENDING SCHOOL AGE PROGRAMS

As required by K.A.R. 28-4-590(d) (1), each operator shall obtain a health history for each child or youth, on a form supplied by the department or approved by the secretary. Each health history is to be maintained in the child's or youth's file on the premises. As required by K.A.R. 28-4-590(d)(2), each operator shall require that each child or youth attending the program has current immunizations as specified in K.A.R. 28-1-20 or has an exemption for religious or medical reasons.

Complete one form for each child or youth attending the School Age Program.

First and Last Name of the Child or Youth	Gender (M or F)	Date of Birth (MM/DD/YYYY)	First day at this program: (MM/DD/YYYY)

First and Last Name of the Child's or Youth's Mother or Guardian

Mother/Guardian's Home Street Address	City	Zip Code	Home Phone # ( )

Mother/Guardian's Work Place Name & Street Address	City	Zip Code	Work Phone # ( )

First and Last Name of the Child's or Youth's Father or Guardian

Father/Guardian's Home Street Address	City	Zip Code	Home Phone # ( )

Father/Guardian's Work Place Name & Street Address	City	Zip Code	Work Phone # ( )

Names and ages of other children in the Child or Youth's Family (Attach additional page if needed.)

Person(s) authorized to pick up the Child or Youth in case of emergency. Include first and last name and Street Address. Attach additional page if needed.	City	Zip Code	Phone Number (during program hours):
1.			
2.			
3.			

First and Last Name of Physician & Street Address	City	Zip Code	Phone Number ( )

Name of Hospital Preference in case of emergency.

Yes	No	N/A	Complete the following information about medications for this child or youth.
			Will this child or youth need to take any nonprescription or prescription medication during their time at the program?
			If yes above, is there signed permission on file?

Circle any of the following conditions or difficulties that affect this child or youth.			
Allergies	**Frequent sore throats/ colds**	**Ear Infections or Aches**	**Heart or Lung Conditions**
Skin Problems	**Asthma**	**Headaches**	**Diabetes**
Vision	**Speech/Communication**	**Hearing**	**Emotion/Behavior**
Other: Please describe.			

If you circled any of the above conditions, please provide additional information that will help the staff members meet the child's or youth's needs while attending the program. (Attach additional page, if needed.)

Provide additional information about your child or youth that might affect him/her while at the School Age Program including any special needs, restrictions to activities, major changes at home or special instructions. (Attach additional page, if needed.

Complete the following information about this child's or youth's immunization status.

Yes	No	
		Did this child or youth attend a public or accredited non-public school in Kansas, Missouri or Oklahoma the previous year?
		If yes, are this child's or youth's immunizations current?
		If yes to both of these questions, you do NOT need to complete the immunization history below. If no to either of the above questions, you must complete the immunization history below for this child or youth or attach a copy of the child's or youth's immunization history.

Please give dates in the space below for ALL immunization series completed by this child or youth. Record MM/DD/YYYY.

		1	2	3	4	5
	DPT, DT*, TD (*DT only if child is allergic to DTP)	/ /	/ /	/ /	/ /	/ /
	POLIO	/ /	/ /	/ /	/ /	
	MMR	/ /	/ /			
Single Dose Only	RUBEOLA (MEASLES)	/ /	/ /			
	MUMPS	/ /	/ /			
	RUBELLA (GERMAN MEASLES)	/ /	/ /			
	HIB (Hemophilus Influ. B) *RECOMMENDED	/ /	/ /	/ /	/ /	
	HBV (Hepatitis B Vaccine) *RECOMMENDED	/ /	/ /	/ /		
	VAR (Varicella-Chicken Pox) *RECOMMENDED	/ /				

Print the First and Last Name of the Person Completing this Health History form	Relationship to the Child/Youth	Date Completed

If the Health History form was completed by a person other than a Parent/Guardian, who provided you with this information?	What is that person's relationship to the child/youth?

I attest, under penalty of perjury, that to the best of my knowledge, the information provided on this form is true and correct.

Signature of person completing this form	Date Signed

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Kansas Department of Health and Environment
Bureau of Family Health
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Child Care Program: (785) 296 -1270 Fax: (785) 296 -0803
Foster Care Program: (785) 296 -1270 Fax: (785) 296 -7025
Website: www.kdheks.gov/kidsnet

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

Written permission for emergency medical treatment must be on file at the facility. Consult with the local emergency medical facility to be sure this form is acceptable. Reference K.A.R. 28-4-127(b)(1)(A). School Age Programs reference K.A.R. 28-4-582(e)(2).

Name of facility exactly as stated on the license.	**License #**

I hereby authorize _____ JCPRD Staff _____ (Name of individual/staff member) and/or

_____ (Name of individual/staff member) who is (are) representative(s) of the

above named facility to give consent for any and all necessary emergency medical care for my child or youth _____

_____ (First and Last Name of Child or Youth) while said child or youth is in said

facility's custody between the dates of _____ and __ until care is terminated .
MM/DD/YYYY MM/DD/YYYY

Signature of Parent or Guardian	**Date Signed**

Witness to Parent's or Guardian's signature if required by the local hospital or clinic.	**Date Signed**

Notarization of Parent's or Guardian's signature if required by local hospital or clinic.

State of Kansas
County of _____

Signed or attested before me on _____ by _____.
MM/DD/YYYY Name of Person

(Seal, if any.)

_____
Signature of notarial officer

Notary Not Required

_____
Title (and Rank)

My appointment expires: _____

List any known allergies or other information about the medical status of this child or youth pertinent in case of emergency:

_____

_____

Is child covered by health insurance? ☐ Yes ☐ No

If yes, complete the following:

Health Insurance Policy Name _____ Policy Number _____

Medical Assistance Program _____ Card Number _____

Military Medical Care I.D. Number _____

If known, date of last Tetanus inoculation:

THE MEDICAL RECORD/ASSESSMENT FORM (OR HEALTH STATUS HISTORY FORM FOR SCHOOL AGE PROGRAMS) AND THE AUTHORIZATION FOR EMERGENCY MEDICAL CARE MUST BE TAKEN TO THE EMERGENCY ROOM. BOTH FORMS MUST ALSO BE IN A VEHICLE WHEN THE CHILD OR YOUTH IS TRANSPORTED BY THE FACILITY.