All Saints Catholic School Childcare
768 Ohio Street
Bangor, Maine 04401
(207)941-9585

SUMMER CAMP ENROLLMENT APPLICATION 2019

Office Use

Check number: ____________________
Admittance Date: ____________________ Date of Dismissal:_____________________________

Medical Conditions/Allergies:____

Child's Name:____ Nickname:_________________________

Address:____ Home Phone:______________________

Gender:______ Birthday:________________ Grade:______ Age as of June 21st _______

Child's Ethnicity:
(Please check one. We are responsible for reporting the following information in our annual reports)

_____American Indian _____Asian ______Native Alaskan _____Black _____Multi-racial
_____Hispanic _____Native Hawaiian _____Pacific Islander _____White

Child's Religion:_________________________________Church Attending:____________________________

Person's Having Legal Custody of Child

Name:____ Relationship to Child:_____________________
Home Address:____
Home Phone:____________________ Cell Phone:______________________ Work
Phone:_______________ Email Address:____
Occupation:____
Business Address:____

Name:____ Relationship to Child:_____________________
Home Address:____
Home Phone:____________________ Cell Phone:______________________ Work
Phone:_______________ Email Address:____
Occupation:____
Business Address:____

If a custody arrangement or agreement exists, explain and attach supporting documentation (including pertinent visitation agreements, or a copy of the court decree). If any of the above information changes, please inform us immediately

Siblings

Name **Age** **Birthdate**

____

____

____

Child Release Information

Children will not under any circumstances be released to any person without the expressed consent to do so by the child's custodial parent(s) or guardian(s). Prior to pick up, please inform the childcare office if someone other than yourself or those listed below are picking up your child.

Name:________________________ Contact Phone:___________ Relationship to child:_____________________

Name:________________________ Contact Phone:___________ Relationship to child:_____________________

Name:________________________ Contact Phone:___________ Relationship to child:_____________________

Registration

See attached Sign Up Sheet

Emergency Information

Persons to be called in case of an emergency if custodial parent(s) or guardian(s) are unavailable.

Name:____ Relationship to child:_______________________
Home Address:___________________________________ Phone Number:______________________________
Business Address:________________________________ Business Phone Number:____________________

Name:____ Relationship to child:_______________________
Home Address:___________________________________ Phone Number:______________________________
Business Address:________________________________ Business Phone Number:____________________

Name:____ Relationship to child:_______________________
Home Address:___________________________________ Phone Number:______________________________
Business Address:________________________________ Business Phone Number:____________________

Medical Record and History

(To be completed by parent/guardian)

Present general health: ____
Special needs: ____
Past serious illness: ____
Medications your child takes:
____

PLEASE NOTE: If your child requires medication to be administered at school please complete an Authorization to Dispense Medication Form, available upon your request.

Child's Physician and Phone Number: ____
Child's Dentist and Phone Number: ____

Does your child see any other doctors besides their physician or dentist? _____________
If yes, please explain: ____
____

1. Does your child have any medical issues? (For example: asthma, epilepsy, etc.) Yes ______ No _______
   If yes, please explain: ____________________________________

2. Have there been any previous hospitalizations? Yes _______ No _______
   If yes, please explain:_____________________________________

3. Any allergies? Yes ______ No______
   If yes, please explain.____________________________________

4. Any previous diseases or illnesses? Yes ______ No______
   If yes, please explain. ______________________

5. Any operations? Yes______ No______
   Dates: ____

6. Any physical handicaps? Yes______ No______
   If yes, please explain:_____________________________________

7. Is there any history of convulsions or seizures in child? Yes _______ No _______
   If so, please explain. _____________________________________

8. Is there any history of diabetes in child? Yes ______ No ______

9. Is there any history of diabetes in family? Yes ______No ______

10. Is there any history of heart trouble in child? Yes ______ No ______

11. Is there any history of heart trouble in family? Yes ______ No _______

12. Is there any history of developmental delays in child? Yes ______ No ______

If so, please explain. ____

Agreements

Hospital Preference ______(initial)

I, ______________________________, hereby give authorization to All Saints Catholic Child Care and its employees to obtain emergency medical treatment for my child in the event of sudden illness or injury.

Hospital preference, if any ___________________________

Sunscreen and Insect Repellant ______(initial)

I, ______________________________, give permission for my child _______________________

To have **sunscreen:** Yes _____ No _____

To have **insect repellant** Yes _____ No _____

Permission will allow staff to apply the above as needed. I will supply sunscreen labeled for my child as needed.

Photos _______(initial)

I, ____________________________, give permission for All Saints Catholic Child Care personnel to:
Photograph my child for brochure of All Saints Catholic Child Care Program Yes _____ No _____
Photograph my child for use within the classroom (non-publicity) Yes ______ No _____

Include my child's class picture in the All Saints Catholic School Yearbook Yes _____ No _____

Photograph my child for picture on the website. Yes _____ No _____

Thirty Day Trial Period Agreement Form

I, __________________________________, consent and agree to a thirty day trial period for
____ dating from his or her first attendance at
All Saints Catholic Child Care.
I understand that if, at any time during this thirty day trial period, the child does not show signs of adjusting or is not ready for this type of preschool experience, based
improper behavior, emotional disturbances, or mental health conditions too severe to be handled by the staff in this environment.

________________________________ ________________________________
(Administrator's Signature) (Parent/Guardian Signature)

____
(Date)

Fee Agreement

I agree to the following conditions regarding care for my child by All Saints Catholic Child Care – Summer Camp

The tuition fee for child care and Summer Camp services is to be paid weekly on Wednesday. If the fee is not paid in any two week period, services may be terminated until the fee is collected, unless arrangements are made with the Director.

FEES ARE AS FOLLOWS:

Please note these are daily charges, **PRICES ARE SUBJECT TO CHANGE.**

Daily Summer Camp Rate - $35

I understand that payment is due in by means of either of the following:

> ______**Tuition Express Weekly Debits –** The checking or savings account on record will be debited weekly for the amount due, per your Fee Agreement.
>
> ______**Prepay –** Prepayment to be made at the start of the Summer Camp Program

Parent's Signature: ______________________________________ Date:____________________

Administrator's Signature:________________________________ Date:____________________

Immunization Records

(to be completed by child's physician)

PATIENT NAME:__________________________ DATE OF BIRTH:____________

DTAP/DTP/DT/TETRA _____________________
DTAP/DTP/DT/TETRA _____________________
DTAP/DTP/DT/TETRA _____________________
DTAP/DTP/DT/TETRA _____________________

ADULT TD ___________________

OPV/IPV _____________________
OPV/IPV _____________________
OPV/IPV _____________________
OPV/IPV _____________________

HEPTB/HIB ___________________
HEPTB/HIB ___________________
HEPTB/HIB ___________________
HEPTB/HIB ___________________

MMR ________________________
MMR ________________________

PNEUMOCOCCAL CONJUGATE
PREVNAR ____________________
PREVNAR ____________________
PREVNAR ____________________
PREVNAR ____________________

HIB ____________________
HIB ____________________
HIB ____________________
HIB ____________________

VARICELLA _______________________
PPD/TINE T ________________________

FLU _______________________________

ALLERGIES ____
CONTRACTED DISEASES ____
EXEMPTIONS FROM VACCINATIONS:
MEDICAL ______________________________RELIGIOUS _________________