**KALEIDOSCOPE OF LEARNING AFTER SCHOOL GYMNASIUM**

**2019-2020 School Age Child Care Enrollment Form**

**Operating Hours 7:00 a.m.-6:00 p.m. (Summer Hours)**

**Grade \_\_\_\_\_\_\_\_\_\_\_ Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Start Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Child’s Full Legal Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Child’s Gender: \_\_\_M \_\_\_F Date of Birth \_\_\_\_\_\_\_\_\_\_ Last School Attended \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **Parents automatically on Authorized Pick-Up****if listed.** | **Mother’s Information/Authorized****Pick-Up** | **Father’s Information/Authorized****Pick-Up** |
| **Name** |  |  |
| **Email Address** |  |  |
| **Home Phone** |  |  |
| **Cell Phone Number** |  |  |
| **Cell Phone Carrier** |  |  |
| **Work Phone** |  |  |
| **Place of Employment** |  |  |
| **Work Address** |  |  |
|  |  |
| **Emergency Pick-Up (other than parents)** |
|  | **Name** | **Relationship** | **Phone** |
| **Contact 1** |  |  |  |
| **Contact 2** |  |  |  |
| **Doctor** |  |  |  |
|  |
| **Authorized Pick-Up (other than parents and emergency pick up)** |
|  | **Name** | **Relationship** | **Phone** |
| **1** |  |  |  |
| **2** |  |  |  |
| **3** |  |  |  |
| **4** |  |  |  |

**Hours of Service Needed during Summer Camp: Drop off \_\_\_\_\_\_am Pickup \_\_\_\_pm**

**Does your child have any special health problems or reactions? \_\_\_\_\_ Asthma \_\_\_\_\_ Allergies**

**If other problems or reactions, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does your child have reactions to \_\_\_\_\_\_\_ Food \_\_\_\_\_\_\_ Medicine \_\_\_\_\_\_\_ Insect Bites**

**What subject area those your child need additional help? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does your child have any known behavior problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does your child have any special needs or disabilities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please read carefully and check the appropriate areas.**

1. **I give permission for the child listed on this application to be photographed or videotaped while in attendance at this center during center activities.**

**\_\_\_\_\_\_My child may be photographed \_\_\_\_\_My child may not be photographed**

1. **I give permission for the child listed on this application to be transported by Kaleidoscope of Learning while in attendance at this center during an emergency, center activities or after school pick up.**

**\_\_\_\_\_\_My child may be transported \_\_\_\_\_My child may not be transported**

1. **I have received a copy of the Mississippi State Department of Health Regulation Summary for Parents.**

**\_\_\_\_\_\_I did receive a copy \_\_\_\_\_\_I did not receive a copy**

1. **Kaleidoscope of Learning has the authority to obtain emergency medical treatment for my child in case of emergency.**

**\_\_\_\_\_\_My child may receive treatment \_\_\_\_\_\_My child may not receive treatment**

1. **My child will eat \_\_\_\_breakfast \_\_\_\_lunch \_\_\_\_\_snack at the center. (Please check)**

**Parent’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| **Registration** | **Summer-$50** | **After School-$50** |  |
| **After School Tuition** | **Monthly-$260** | **Bi-Weekly-$130** | **Drop-In Rate-$25 a day** |
| **Summer Camp** | **Monthly-$400** | **Bi-Weekly-$200** | **Activity Fee $100-June & July** |

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**FOR OFFICE USE ONLY: Date of Acceptance (start date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Certification of Immunization Form 121 – Date received \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Withdrawal \_\_\_\_\_\_ Reason for Withdrawal \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**KOL Staff Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**