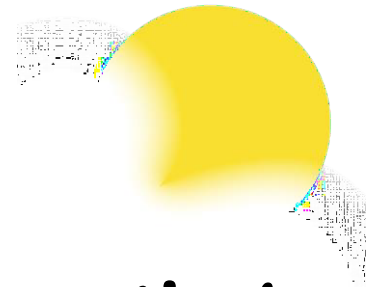


Parks
Make
Life
Better!

City of Carson

Recreation Division



After School Kids Club

Application Packet



CITY OF CARSON
RECREATION DIVISION

KIDS CLUB PROGRAM – REGISTRATION CONTRACT

Child's name: _____ Age: _____

Address: _____

Home Telephone: () _____ Birth Date: _____ Gender: M F

Name of School: _____ Grade: _____

Time your child will be attending from _____ to _____

Days your child will be attending the program: M T W Th F

I agree to pay the above weekly fee until a new contract is executed or canceled. I also agree to pay the weekly fee in advance, due on the Friday prior to the upcoming week in which my child will attend. I agree to pay the contracted fees.

Parent/Legal Guardian Signature

Date

Staff Signature

Date

To be filled out by staff only.

Park Site: _____ Start Date: _____ \$ _____ weekly rate

PARENT RESPONSIBILITIES/AGREEMENT: Please initial each of the following to indicate that you have read, understand, and agree with each item.

Your Initials:

1. _____ My child is not allowed to come and go freely from the Kids Club Program site.
2. _____ I (or an authorized person) must sign my child "in" and "out" each day.
3. _____ I will maintain open communication with the Program Site Director/Teacher about my child and keep him/her informed of any pertinent changes.
4. _____ I must notify the Program Site Director/Teacher in writing of any daily departure changes.
5. _____ I must contact the Program Site Director/Teacher when my child will be absent or will be picked up early from the Kids Club Program. I realize this is for my child's protection.
6. _____ I will NOT send my child to the Kids Club Program if they are presenting Covid symptoms.

7. _____ If a medical emergency arises; the Kids Club Program staff will first attempt to contact me. If I cannot be reached, the people on the emergency list will be notified. If the emergency is such that immediate hospital attention is necessary, the Kids Club Program staff will immediately contact the paramedics, and if they determine that it is necessary, they will arrange for my child to be transported to the nearest available medical facility. I will be responsible for all costs incurred.
8. _____ The Kids Club Program will operate from 2:30 p.m. to 6:00 p.m., Monday through Friday. The program will not operate on legal holidays.
9. _____ It is my responsibility to see that my child is picked up by the designated pick-up time.
10. _____ I verify that I have given permission for the City of Carson to use my child's photograph for publicity purposes in any forthcoming brochures. I further state that I release all rights and am fully cognizant of this agreement.
11. _____ I understand that I cannot send any medicine for my child to take/use while he/she attends the Kids Club Program without prior written approval. For further information, contact the Recreation Superintendent at (310) 847-3570.
12. _____ I understand that staff will not assume pay responsibility for storing any medical equipment without the prior written approval of the City of Carson. My child must keep any medical equipment with him/her at all times. For further information, contact the Recreation Superintendent at (310) 847-3570

BILLING PROCEDURES:

1. _____ I agree to pay the City of Carson Kids Club Program fee on or before the Friday prior to the week in which my child will attend.
2. _____ I will pay for contracted hours of service and am responsible for payment whether my child attends Kids Club or is absent.
3. _____ I understand that credits or refunds in the case of prolonged illness (five or more consecutive days) may only be approved by the Recreation Division Superintendent.
4. _____ I will be notified in advanced of any rate increases.
5. _____ I am aware that the Kids Club Program closing time is 6:00 p.m.
6. _____ I will notify the Program Site Director/Teacher of any changes of information as entered on this record.

Note: All payments must be paid through ActiveNet.

Parent/Legal Guardian Signature

Date

Print Name

Date

Enrollment in the Kids Club Program shall be granted to children without regard to race, color, or national origin.

NOTE: Help the City of Carson respond to the Americans with Disabilities Act (ADA), by making parks, recreation programs, and facilities more accessible. If you experience any problems or difficulties in using facilities or programs, please submit (in writing) your concerns or suggestions for improvements to Community Services/Parks and Recreation Department, Attention: Tim Grierson, Recreation Division Superintendent, 18601 South. Main Street, Carson, California 90248 or call (310) 847-3570.

IDENTIFICATION AND EMERGENCY INFORMATION
CHILD CARE CENTERS/FAMILY CHILD CARE HOMES
To Be Completed by Parent or Authorized Representative

CHILD'S NAME	LAST	MIDDLE	FIRST	SEX	TELEPHONE ()
ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
					BIRTHDATE
FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
					HOME TELEPHONE ()
MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
					HOME TELEPHONE ()
PERSON RESPONSIBLE FOR CHILD	LAST NAME	MIDDLE	FIRST	HOME TELEPHONE ()	BUSINESS TELEPHONE ()

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ()
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ()

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

CALL EMERGENCY HOSPITAL OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE
---	------

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	DATE LEFT
-------------------	-----------

CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

_____ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____. THIS CARE MAY BE GIVEN UNDER
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD
NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

_____ DATE

_____ PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

_____ HOME ADDRESS

HOME PHONE
()

WORK PHONE
()

CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.
2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.
3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.
4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.
5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.
6. Receive from the licensee the name, address and telephone number of the local licensing office.

Licensing Office Name: _____

Licensing Office Address: _____

Licensing Office Telephone #: _____

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.
8. Receive, from the licensee, the Caregiver Background Check Process form.

NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.

For the Department of Justice "Registered Sex Offender" database, go to www.meganslaw.ca.gov

LIC 995 (9/08)

(Detach Here - Give Upper Portion to Parents)

~~ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS~~ (Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of _____, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

Name of Child Care Center

Signature (Parent/Authorized Representative)

Date

NOTE: This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/authorized representative.

For the Department of Justice "Registered Sex Offender" database go to www.meganslaw.ca.gov

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME	DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?	
MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME	DOES MOTHER/MOTHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?	
IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?	DATE OF LAST PHYSICAL/MEDICAL EXAMINATION	

DEVELOPMENTAL HISTORY (*For infants and preschool-age children only)

WALKED AT*	MONTHS	BEGAN TALKING AT*	MONTHS	TOILET TRAINING STARTED AT*	MONTHS
------------	--------	-------------------	--------	-----------------------------	--------

PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Poliomyelitis	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Ten-Day Measles (Rubeola)	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Whooping cough		<input type="checkbox"/> Three-Day Measles (Rubella)	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF
--	------------------------	---

DAILY ROUTINES (*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*
DIET PATTERN: (What does child usually eat for these meals?)	BREAKFAST LUNCH DINNER	WHAT ARE USUAL EATING HOURS? BREAKFAST _____ LUNCH _____ DINNER _____
ANY FOOD DISLIKES?	ANY EATING PROBLEMS?	
IS CHILD TOILET TRAINED?*	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?*
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
WORD USED FOR "BOWEL MOVEMENT"*	WORD USED FOR URINATION*	

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE?	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)?	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
DOES CHILD USE ANY SPECIAL DEVICE(S):	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME?	IF YES, WHAT KIND:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S SIGNATURE	DATE
--------------------	------