# City of Carson

Recreation and Human Services Division

# After School Kids Club

## Application Packet

CITY OF CARSON
RECREATION AND HUMAN SERVICES 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 Kids club if they are presenting Covid symptoms.

6. ______ 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.
7. ______ The Kids Club Program will operate from 2:30 p.m. to 6 p.m., Monday through Friday. The program will not operate on legal holidays.
8. ______ It is my responsibility to see that my child is picked up by the designated pick-up time.
9. ______ 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.
10. ______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.
11. ______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 and Human Services 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 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 Active net .

| ____________________________ | __________ | ____________________________ | __________ |
|---|---|---|---|
| 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 Parks and Recreation Department, Attention: Arnold Carraway, Recreation and Human Services Superintendent, 2400 E. Dominguez Street, Carson, CA 90810, or call (310) 847-3570.

# CITY OF CARSON - COMMUNITY SERVICES DEPARTMENT
# WAIVER, RELEASE, INDEMNIFICATION AND HOLD HARMLESS FORM (MINOR PARTICIPANT)

*(This form is intended for Participants under 18 years of age. If Participant is 18 or over, please use the form entitled, "WAIVER, RELEASE, INDEMNIFICATION AND HOLD HARMLESS FORM (ADULT PARTICIPANT)")*

Name of Program or Event: ______________________________________________

Date and Time of Program or Event:_______________________________________

Location of Program or Event: ____________________________________________

*(Information Above this Line to be Completed by City Staff)*

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Name of Participant: ____________________ ________________________ ____
(First) (Last) (M.I.)

Birthdate of Participant: ______________________ Age of Participant: ______________

Name of Parent or Legal Guardian:

_________________________________ __________________________________________ ____
(First) (Last) (M.I.)

Address: ____________________________________________________________________________
(Street) (City) (Zip)

Phone Number: (______) ________-___________

I, the undersigned, certify that I am 18 years of age or over and that I am the parent or legal guardian of Participant. I request, permit, and consent to Participant's participation in the above-referenced program or event ("Program"). I certify and represent that I am aware of no medical condition or physical or mental impediment of Participant that would endanger Participant when participating in the Program. I understand that the Program involves the risk of accident and bodily injury, death, or property damage to Participant, and I agree to assume such risks.

In consideration for Participant's participation in the Program, I hereby waive, release and discharge the City of Carson, its officers, agents, and employees ("City"), from and against any and all claims or liabilities to me or any other person, including but not limited to claims or liabilities for bodily injury, death, or property damage, arising from or related in any way to Participant's participation in the Program, including the negligence of the City or any other participants in the Program, and I agree to waive my rights to make any such claims through any action or proceeding against the City. However, I understand that this paragraph is not intended to release any party from any act or omission of "gross negligence."

To the full extent permitted by law, I agree to indemnify, defend and hold harmless the City against, and will hold and save the City and each of them harmless from, any and all actions, either judicial, administrative, arbitration or regulatory claims, damages to persons or property, losses, costs, penalties, obligations, errors, omissions or liabilities, whether actual or threatened, that may be asserted or claimed by any person, firm or entity arising out of or in connection with Participant's participation in the Program. This indemnity obligation shall be binding on my heirs, successors and assigns and shall not expire.

I acknowledge and agree that City is not responsible for providing medical treatment or medication of any kind to Participant, or for supervising Participant, during or in connection with Participant's participation in the Program or otherwise. However, I authorize, consent, and waive any claim related to City seeking or providing for emergency medical care for Participant in the event City determines the need has arisen during or in connection with Participant's participation in the Program, provided that City shall first make an effort to contact me by calling me at the phone number above, and shall only proceed with seeking or providing for such treatment absent my directive in the event I do not answer or respond immediately.

I hereby grant City the right to photograph or video-record Participant during or in connection with the Program, and to use Participant's photographed or video-recorded likeness, and any image, silhouette, or reproduction of the voice or appearance of Participant taken during or in connection with the Program ("Likeness"), for any purpose, including publicity and promotion of City and its events, and creation or production of materials in any form for such purpose, with no claim of entitlement to any license fee or royalty of any kind from City. I hereby waive any right to the intellectual property of Participant's Likeness. The rights granted by me hereunder shall not expire.
No oral representations, statements or inducements, apart from this written form, have been made with regard to the subject matter of this form. If any portion of this form is declared invalid by a court of competent jurisdiction, the remainder shall continue in full force and effect.

**By signing below, I acknowledge and represent that I have read and understand the above, and that I voluntarily agree to its terms.**

Signature of Parent/Legal Guardian: ______________________________ Date: ____________________

# 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* | BEGAN TALKING AT* | TOILET TRAINING STARTED AT* |
|---|---|---|
| MONTHS | MONTHS | MONTHS |

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

| | DATES | | DATES | | DATES |
|---|---|---|---|---|---|
| ☐ Chicken Pox | | ☐ Diabetes | | ☐ Poliomyelitis | |
| ☐ Asthma | | ☐ Epilepsy | | ☐ Ten-Day Measles (Rubeola) | |
| ☐ Rheumatic Fever | | ☐ Whooping cough | | ☐ Three-Day Measles (Rubella) | |
| ☐ Hay Fever | | ☐ Mumps | | | |

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

| DOES CHILD HAVE FREQUENT COLDS? ☐ YES ☐ 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?) | | WHAT ARE USUAL EATING HOURS? |
|---|---|---|
| | BREAKFAST | BREAKFAST ____________ |
| | LUNCH | LUNCH____________ |
| | DINNER | DINNER |

| ANY FOOD DISLIKES? | ANY EATING PROBLEMS? |
|---|---|

| IS CHILD TOILET TRAINED?* ☐ YES ☐ NO | IF YES, AT WHAT STAGE:* | ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO | WHAT IS USUAL TIME?* |
|---|---|---|---|

| WORD USED FOR "BOWEL MOVEMENT"* | WORD USED FOR URINATION* |
|---|---|

PARENT'S EVALUATION OF CHILD'S HEALTH

| IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? ☐ YES ☐ NO | IF YES, NAME OF DOCTOR: | DOES CHILD TAKE PRESCRIBED MEDICATION(S)? ☐ YES ☐ NO | IF YES, WHAT KIND AND ANY SIDE EFFECTS: |
|---|---|---|---|
| DOES CHILD USE ANY SPECIAL DEVICE(S): ☐ YES ☐ NO | IF YES, WHAT KIND: | DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? ☐ YES ☐ NO | IF YES, WHAT KIND: |

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 |
|---|---|