CIPCC SUMMER CAMP REGISTRATION FORM 2023

CHILD _____ D.O.B.____/____/____ PHONE_____

Weekly Tuition: $249.00 per week or $60.00 per day (when available)

(please circle)	Tuition Due
6/19-6/23 M T W Th F	**$**
6/26-6/30 M T W Th F	**$**
7/03-7/07 M W Th F (Closed 07/04)	**$**
07/10-07/14 M T W Th F	**$**
07/17-07/21 M T W Th F	**$**
07/24-07/28 M T W Th F	**$**
07/31-08/04 M T W Th F	**$**
8/07-08/11 M T W Th F	**$**
08/14-08/18 M T W Th F	**$**
8/22-08/26	**NO CAMP**
TOTAL DUE	**$**
CCFAP or GISU VOUCHER	**$**
Remaining tuition	**$**

I understand that I am contracting summer camp care and agree to abide by the following terms and conditions:
Summer camp tuition payments of the contracted fee indicated below will be made in three equal payments, due on or before the 15th of each summer month. The fee is due regardless of holidays, snow days or absences. If your tuition is one week late, the late fee will be $10.00. If payment it two weeks late, the late fee will be $20.00. If the bank returns a check, the parent is charged both the late fee and a $10.00 returned check fee. If payment for contracted care is not received and no arrangement for payment has been made with the Director, the child's contract will be cancelled, and s/he will not be permitted to attend the program. Before the child may attend the program again, past due tuition must be paid in full, and a new schedule arrangement must be made.

Tuition dates:

- ☐ 06/15/2023
- ☐ 07/15/2023
- ☐ 08/15/2023

Total Tuition due for camp: $_____
Payment amount calculation: $_____

By signing you are confirming you have read, understand, and agree to follow the policies while your child/children attend the Center. The Center may amend the policies and procedures annually. The Champlain Islands Parent Child Center- South reserves the right to cancel this contract if our policies are not upheld.

_____

Parent/Guardian signature Date

_____

Director signature Date

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RELEASE AND EMERGENCY FORM

CHILD'S FULL NAME: _____ DOB:_____ HOME PHONE: _____

HOME ADDRESS: _____

CHILD'S DENTIST & PHONE NUMBER: _____

CHILD'S PHYSICIAN & PHONE NUMBER: _____

ALLERGIES: _____ MEDICATIONS: _____

BRINGING AND PICKING UP CHILDREN

I hereby allow my child to be brought and/or picked up by the following persons other than his or her parents. These are exclusively the only people guaranteed access to my children unless otherwise stated:

_____ _____

_____ _____

Staff may withhold a child from a parent only if there is a court order prohibiting release to that particular parent, and if a copy of that court order is on file at the Center.

PARENT/GUARDIAN'S FULL NAME: _____

(H) _____ (C): _____ Email: _____
EMPLOYER: _____ (W) _____

PARENT/GUARDIAN'S FULL NAME: _____

(H) _____ (C): _____ Email: _____
EMPLOYER: _____ (W) _____

PARENT/GUARDIAN with LEGAL CUSTODY _____

EMERGENCY CONTACTS

***CONTACTS MUST BE OTHER THAN PARENTS (We always try to contact parents first)**

PRIMARY EMERGENCY CONTACT
FULL NAME: _____

(H) _____ (C): _____ (W) _____
Relationship to child: _____

SECONDARY EMERGENCYCONTACT
FULL NAME: _____

(H) _____ (C): _____ (W) _____
Relationship to child: _____

OUT OF TOWN EMERGENCY CONTACT (if different from above)
FULL NAME: _____

(H) _____ (C): _____ (W) _____
Relationship to child: _____

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PERMISSION FORM

CHILD'S NAME _____

Emergency
I hereby give permission for CIPCC-South to call South Hero Rescue Squad in the event of an emergency. Rescue personnel will transport my child to University of Vermont Medical Center in Burlington. If necessary the Champlain Islands Parent Child Center-South is authorized to seek treatment in my absence. I understand that all possible attempts to contact me will be made in an emergency.

Evacuation
I hereby give permission for CIPCC-South staff to transport my child to the designated emergency shelter in the event of an entire area evacuation. Children will be escorted to Folsom Educational Center in the case of a prolonged Center evacuation.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

Topical non-prescription medications (please circle one)

I DO / DO NOT give permission for CIPCC-South staff to apply topical non-prescription medications such as Neosporin.

Spontaneous Walks (please circle one)

I DO / DO NOT give permission for my child to go on spontaneous walks in the community with CIPCC-South Staff. I understand that all safety precautions will be followed and I will be informed of such walks at the end of the day.

Photographs (please circle one)

I DO / DO NOT agree for my child's image to be published in Center materials such as program brochures, web pages, etc. to publicize the Center and our services. We also take photographs during our programs for curriculum documentation purposes that would not be published.

Water Activities (please circle one)

I DO / DO NOT give permission for my child to participate in water activities including sprinklers and water games.

Sunscreen

All children at CIPCC-South need to wear sunscreen while playing outdoors. We ask that each family supply a bottle of sunscreen.

I give the CIPCC-South staff permission to apply sunscreen to my child _____

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

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MEDICAL HISTORY

Child's Information			
First Name	MI	Last Name	Date of Birth
Nickname / Preferred Name		Gender: ☐ Male ☐ Female	

Health Insurance	**Health Information**
Primary Health Insurance: ☐ Medicaid / Dr. Dynasaur ☐ Private ☐ None ☐ Other (please specify): _____	I would like to learn more about the following health topics: ☐ First Aid ☐ What to do when my child is sick ☐ Taking care of my child's teeth ☐ Other (please specify): _____
I would like more information about health insurance: ☐ Yes ☐ No	I learn best by: ☐ Reading ☐ Going to a class and listening ☐ Doing hands-on activities ☐ Other (please specify):_____
Medical Home	**Dental Home**
Child's doctor:	Child's dentist:
Date of child's last physical:	Date of child's last dental visit:
Health Conditions	**Medications**
Please list child's health conditions and symptoms:	Please list child's current medications: Medications — Needed on site? _____ ☐ Yes ☐ No _____ ☐ Yes ☐ No _____ ☐ Yes ☐ No

Additional Information	
Check any of the following which apply to your child: ☐ Autism ☐ Developmental Delay ☐ Emotional/Behavioral Disability ☐ Hearing Impairment / Deafness ☐ Impairment of Motor Function ☐ Visual Impairment / Blindness ☐ Other Health Impairment (please specify):_____ _____	My child has/has had (please check, if applicable): ☐ **IEP** Date: _____ Completed at/by: _____ ☐ **IFSP** Date: _____ Completed at/by: _____ ☐ **Comprehensive Evaluation** Date: _____ Completed at/by: _____
Please specify any concerns you may have about your child's behavior or development:	