themba

CREATIVE LEARNING CENTER LLC

2018

summer camp

REGISTRATION PACKET

Themba CLC Summer 2018 Camp Registration

Child (or Children) Information
Child 1:
Name: ____ (Full Name)

Date of Birth: ____

Age as of June 2018: ____

Child 2 *(May or may not be applicable)*
Name: ____ (Full Name)

Date of Birth: ____

Age as of June 2018: ____

Child 3 *(May or may not be applicable)*
Name: ____ (Full Name)

Date of Birth: ____

Age as of June 2018: ____

Parent/Guardian Information:

Mother
Name: ____ (Full Name)

Home Phone: ____

Work Phone: ____

Email: ____

Home Address: ____

Father
Name: ____ (Full Name)

Home Phone: ____

Work Phone: ____

Email: ____

Home Address: ____

Session Selections

For Child one, __________________ (Child's Name), you have made the following selection.

1st Child: ________________________
Name

SESSIONS	CHECK IF ATTENDING	ALL
Session 1 -- June 18-June 29 Robotic Engineering Camp	☐	☐
Session 2 – July 1- July20	☐	
(3) week sessions	☐	
Session 3 -- July 23- Aug 10	☐	
(3) week sessions	☐	
Session 4 – August 13-31	☐	
(3) week sessions	☐	
	☐	
	☐	
	☐	

2nd Child (if applicable): ________________________
Name

SESSIONS	CHECK IF ATTENDING	ALL
Session 1 -- June 18-June 29 Robotic Engineering Camp	☐	☐
Session 2 – July 1- July 20	☐	
(3) week sessions	☐	
Session 3- July 23-Aug 10	☐	
(3) week sessions	☐	
Session 4- August 13-31	☐	
(3) week sessions	☐	
	☐	
	☐	
	☐	

3rd Child (if applicable): ________________________
Name

SESSIONS	CHECK IF ATTENDING	ALL
Session 1 -- June 18-June 29 Two weeks only	☐	☐
Session 2 – July 1- July20	☐	
Session 3 – July 23 –Aug 10	☐	
Session 4 – Aug 13- Aug 31	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	

Master Field Trip Permission

I, ________________________ (parent/guardian), give permission for my child (or children), whose name (or names) is/are listed below, to attend all field trips during the summer program at Themba Creative Learning Center.

Registered name(s):

____
____

In case of an emergency, please contact ______________________, who is the _________

You are informing Themba CLC of the following special instructions:
____
____

____
____

Summer Program Shirts for Children:

For child 1, __________________I would like to have a/an ___________________.
For child 2, __________________I would like to have a/an ___________________.
For child 3, __________________I would like to have a/an ___________________.

Should it be necessary for your child to have medical treatment while participating in this trip, I hereby give Themba Creative Learning, and its staff permission to use their judgment in obtaining medical services, and I give permission to the physician selected by Themba Creative Learning Center to render medical treatment deemed necessary and appropriate by the physician? I further understand Themba Creative Learning Center has no insurance covering such medical or hospital costs and, therefore, any cost incurred for such treatment shall be MY sole responsibility.

My child has the following special needs. I will send the appropriate medical and physical supports for my child for each field trip:

By my signature below and/or having checked the box on the website pertaining to this document, implies that I, have read, understood, and agreed to waive all claims against Themba Creative Learning Center, LLC and its staff for the injury, accident, illness or death occurring or by reasons of field trip authorized by this document, and that I have granted permission to the name or names of children written above to participate in all field trips.

Parent or Guardian: ____

Signature: ___________________________________Date: _________________________

Themba CLC Summer Program
General Information and Agreement

Registration:

I agree to pay a non-refundable registration fee of $50 per child. I understand that my child or children is/are not officially registered for the summer camp until I have paid the registration fee and completed the entire registration package.

Agreed Upon Hours:

For your convenience, Themba CLC Summer Program is open 7:30am - 6:00pm.
I understand and agree to arrive with my child by 9am or notify the center's Director by 8 am if my child will be late or absent. Children will not be admitted after 10am without a doctor's note.

Session Requirements:

I understand that I choose sessions at a time not weekly, Themba CLC reserves a slot for my child. Each session is group into (3) week intervals, you may not split up the sessions at any given time.

I understand that I am responsible for all the session I have chosen whether my child attends or not.

I understand that if I do not pay for a chosen session, Themba CLC has the right to immediately terminate my contract and seek legal action against me for any unpaid commitment.

Summer Registration Fees:

Registration Fee (Non-Refundable) ---- $50.00

Weekly Summer Camp- $225.00 per wk. includes most trips & All Activity Fees

Early bird Special Rate- $25.00 off- Registration Fee

I agree, that should I be late remitting the weekly due fees for the summer camp, I am responsible for the late fee of $10.00 for each day past due. I also agree to pay a $35.00 bank fee if the credit card or check doesn't process on due date.______ Initial

I also agree to pick up my child before the center closes at 6:00pm. If I am late picking up, I agree to pay $15.00 per the first one to five minutes I am late & $1 per each additional minute thereafter, per child for each minute I'm late picking up my child or children. Payment is due to the office at pick-up ____ Initial

Withdrawals and Dismissals

I understand that the Director reserves the rights to dismiss, without refund, any child that does not comply with the guidance policy and behavior standards of Themba CLC.
I understand that the Director can dismiss a child any time the Director determines that the dismissal is in the best interest of a child and/or Themba CLC. If my child is dismissed, I agree to pay for the used time. ____ Initial

What to Bring

Please label all items your child brings to camp. This includes swim suits, towels, hats, etc. Children are not allowed to bring toys, games (including electronic games), cell phones, and ipods/ipads to camp. Themba is not responsible for lost, broken or stolen items. Each child must bring a reusable water bottle, a composition notebook, a folder and pencils. ____ Initial

What to Wear

All children must wear sneakers (no sandals) to camp. Camp-T shirts are required for all field trips. Students must wear swim shoes during swim time and appropriate swim wear. (two-piece swim suits are prohibited). ____ Initial

I understand that Themba CLC is not liable for any personal items my child brings to the program (It is advised to leave personal and favorite items at home).

Health

I agree to complete the health record and medical release for and card and provide a shot record before my child (or children can attend the summer program. The card provides parent parental authorization and signature for emergency medical treatment. Any skin cream must be put on prior to attending Themba.

Photo and Media Release

I grant permission for my child to appear in person or in voice, video or photographic presentation for non-commercial radio, television, internet or print media reports and/or media campaign(s) resulting from participation in this program and its activities. These photographs, videos, may be used for illustrations, publications and websites only. We will not release the identity or identify any child by name. ______ Initial

I agree that my child must:

- ☐ Dress casually
- ☐ Wear tennis shoes at all times
- ☐ Wear camp issued T-shirts and their swimwear and bring a reusable water bottle, towel and backpack on the swim days.
- ☐ Bring a Composition Notebook, Folder and pencils

I understand that by signing this agreement, I________________________________, will register my child for a session or sessions at Themba CLC, I therefore agree to all terms as stated in this document and acknowledge receipt of this signed agreement.

Date____

Director's Approval____

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

HEALTH INVENTORY

Information and Instructions for Parents/Guardians

REQUIRED INFORMATION

The following information is required prior to a child attending a Maryland State Department of Education licensed, registered or approved child care or nursery school:

- ***A physical examination*** *by a physician or certified nurse practitioner completed no more than twelve months prior to attending child care. A Physical Examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene shall be used to meet this requirement (See COMAR 13A.15.03.02, 13A.16.03.02 and13A.17.03.02).*
- ***Evidence of immunizations****. A Maryland Immunization Certification form for newly enrolling children may be obtained from the local health department or from school personnel. The immunization certification form (DHMH 896) or a printed or a computer generated immunization record form and the required immunizations must be completed before a child may attend. This form can be found at: http://ideha.dhmh.maryland.gov/IMMUN/pdf/896_form.pdf*
- ***Evidence of Blood-Lead Testing for children living in designated at risk areas****. The blood-lead testing certificate (DHMH 4620) (or another written document signed by a Health Care Practitioner) shall be used to meet this requirement. This form can be found at: http://apps.fcps.org/dept/health/MarylandDHMHBloodLeadTestingCertificateDHMH4620.pdf*

EXEMPTIONS

Exemptions from a physical examination, immunizations and Blood-Lead testing are permitted if the family has an objection based on their religious beliefs and practices. The Blood-Lead certificate must be signed by a Health Care Practitioner stating a questionnaire was done.

Children may also be exempted from immunization requirements if a physician, nurse practitioner or health department official certifies that there is a medical reason for the child not to receive a vaccine.

The health information on this form will be available only to those health and child care provider or child care personnel who have a legitimate care responsibility for your child.

INSTRUCTIONS

Please complete Part I of this Physical Examination form. Part II must be completed by a physician or nurse practitioner, or a copy of your child's physical examination must be attached to this form.

If your child requires medication to be administered during child care hours, you must have the physician complete a Medication Authorization Form (OCC 1216) for each medication. The Medication Authorization Form can be obtained at

http://www.marylandpublicschools.org/NR/rdonlyres/B0050A99-6B3C-4396-A996-CC9405971A42/30754/1216_MedAuth_r120511.pdf

If you do not have access to a physician or nurse practitioner or if your child requires an individualized health care plan, contact your local Health Department.

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Child's Name: ______________________ Last First Middle **Birth date:** ________ Mo / Day / Yr **Sex** M ☐ F ☐

Address: ______________________ Number Street Apt# City State Zip

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		W:	C:	H:
		W:	C:	H:

Where do you usually take your child for routine medical care? Name:

Address: **Phone Number:**

When was the last time your child had a physical exam? Month: Year:

Where do you usually take your child for dental care? Name:

Address: **Phone Number:**

ASSESSMENT OF CHILD'S HEALTH - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.

	Yes	No	Comments (required for any Yes answer)
Allergies (Food, Insects, Drugs, Latex, etc.)	☐	☐	
Allergies (Seasonal)	☐	☐	
Asthma or Breathing	☐	☐	
Behavioral or Emotional	☐	☐	
Birth Defect(s)	☐	☐	
Bladder	☐	☐	
Bleeding	☐	☐	
Bowels	☐	☐	
Cerebral Palsy	☐	☐	
Coughing	☐	☐	
Developmental Delay	☐	☐	
Diabetes	☐	☐	
Ears or Deafness	☐	☐	
Eyes or Vision	☐	☐	
Head Injury	☐	☐	
Heart	☐	☐	
Hospitalization (When, Where)	☐	☐	
Lead Poisoning/Exposure	☐	☐	
Life Threatening Allergic Reactions	☐	☐	
Limits on Physical Activity	☐	☐	
Meningitis	☐	☐	
Prematurity	☐	☐	
Seizures	☐	☐	
Sickle Cell Disease	☐	☐	
Speech/Language	☐	☐	
Surgery	☐	☐	
Other	☐	☐	

Does your child take medication (prescription or non-prescription) at any time?

☐ No ☐ Yes, name(s) of medication(s):

Does your child receive any special treatments? (nebulizer, epi-pen, etc.)

☐ No ☐ Yes, type of treatment:

Does your child require any special procedures? (catheterization, G-Tube, etc.)

☐ No ☐ Yes, what procedure(s):

I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE.

I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature of Parent/Guardian Date

PART II - CHILD HEALTH ASSESSMENT
To be completed *ONLY* by Physician/Nurse Practitioner

Child's Name:				**Birth Date:**		**Sex**
	Last	First	Middle		Month / Day / Year	M ☐ F☐

1. Does the child named above have a diagnosed medical condition?

☐No ☐Yes, describe:

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is in child care? (e.g., seizure, allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE and describe emergency action(s) on the emergency card.

☐No ☐Yes, describe:

3. PE Findings

Health Area	**WNL**	**ABNL**	**Not Evaluated**	**Health Area**	**WNL**	**ABNL**	**Not Evaluated**
Attention Deficit/Hyperactivity	☐	☐	☐	Lead Exposure/Elevated Lead	☐	☐	☐
Behavior/Adjustment	☐	☐	☐	Mobility	☐	☐	☐
Bowel/Bladder	☐	☐	☐	Musculoskeletal/orthopedic	☐	☐	☐
Cardiac/murmur	☐	☐	☐	Neurological	☐	☐	☐
Dental	☐	☐	☐	Nutrition	☐	☐	☐
Development	☐	☐	☐	Physical Illness/Impairment	☐	☐	☐
Endocrine	☐	☐	☐	Psychosocial	☐	☐	☐
ENT	☐	☐	☐	Respiratory	☐	☐	☐
GI	☐	☐	☐	Skin	☐	☐	☐
GU	☐	☐	☐	Speech/Language	☐	☐	☐
Hearing	☐	☐	☐	Vision	☐	☐	☐
Immunodeficiency	☐	☐	☐	Other:	☐	☐	

REMARKS: (Please explain any abnormal findings.)

4. RECORD OF IMMUNIZATIONS – DHMH 896/or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider **or** a computer generated immunization record must be provided. (This form may be obtained from: http://ideha.dhmh.maryland.gov/IMMUN/pdf/896_form.pdf)

RELIGIOUS OBJECTION:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunizations being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Parent/Guardian Signature: Date:

5. Is the child on medication?

☐No ☐Yes, indicate medication and diagnosis:

(OCC 1216 Medication Authorization Form must be completed to administer medication in child care).

6. Should there be any restriction of physical activity in child care?

☐No ☐Yes, specify nature and duration of restriction:

7. Test/Measurement	Results	Date Taken
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test Indicated: ☐Yes ☐No		

(Child's Name) **has had a complete physical examination and any concerns have been noted above.**

Additional Comments:

Physician/Nurse Practitioner (Type or Print):	Phone Number:	Physician/Nurse Practitioner Signature:	Date:

THEMBA CREATIVE

Early Learning Centers

Medical Authorization to Treat a Minor

Authorization is given to any one of the following:

THEMBA CREATIVE Early Learning Centers and staff members acting as agents of THEMBA CREATIVE Early Learning Centers

From:

____

Full name of parent(s) or guardian of child

____

Address and phone number

to consent to unexpected or emergency medical and dental treatment and surgical care for my/our child/children on my/our behalf, and to consent to hospitalization if, at time of injury or illness, it is recommended by a private physician or consulting physician.

Name(s) of Minors Birthdates Allergies & Special Conditions

1 ____

2 ____

3 ____

4 ____

I/We will be responsible for charges incurred for any emergency service, including; ambulance, medical, dental or surgical treatment and/or hospitalization rendered by reason of this authorization.

For further emergency Contact please provide Child's mother and father employer information:

Mother Employer ____

Address________________________City____________State ____________

Phone________________________

Father Employer ____

Address________________________City____________State ____________

Phone________________________

____

Signature of Parent Date

____

Signature of Parent Date

Meal Benefit Application for Themba Creative Learning Center

July 1, 2017- June 30, 2018

For more information, read **Instructions for Completing** or call: [phone number]

Step 1 List all enrolled children (if more spaces are required for additional names, attach another sheet of paper).

Children in **Foster Care** and children who meet the definition of **Homeless, Migrant, Runaway, Head Start, Early Head Start or Even Start** are eligible for free meals. If **ALL** children listed are foster, homeless, migrant, runaway or in Head Start, Early Head Start or Even Start, skip to Step 4.

First and Last Names of All ENROLLED	Check all that apply:					
	Foster Child	Homeless	Migrant	Runaway	Head Start Early Head Start	Even Start

Step 2 Do any Household Members (including you) currently participate in the Food Supplement Program (FSP) or Temporary Cash Assistance (TCA)? **Circle One:** Yes No

If you answered **NO**, complete Step 3.

If you answered **YES**, provide a case number then go to Step 4

Case Number:

Step 3 Report Income for ALL Household Members (skip this step if you answered 'Yes' to Step 2)

List all Household Members (including yourself) even if they do not receive income. For each Household Member listed, if they receive income, report total gross income (before taxes) for each source in whole dollars only. If they do not receive income from any source, enter '0'. If you enter '0' or leave any fields blank you are certifying (promising) that there is no income to report.

How Often = Weekly, Every 2 Weeks, Monthly, Twice a Month or Yearly

First and Last Names of ALL Household Members	Earnings from Work		Child Support, Alimony, Public Assistance		Pensions, Retirement, Other Income	
	Income	How Often?	Income	How Often?	Income	How Often?

Total Household Members (Children and Adults):

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member:

Check if No SSN:

Step 4 Contact Information and Adult Signature

I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that officials may verify (check) the information. I am aware that if I purposely give false information, I may be prosecuted under applicable State and Federal laws. I understand my child's eligibility status may be shared as allowed by law.

Printed Name:		Signature:	
Street Address:			
Date:		Phone #:	

Step 5 OPTIONAL: Children's Racial and Ethnic Identities

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community.

Ethnicity (Check One):
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (Check one or more):
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

DO NOT FILL OUT THIS SECTION. CENTER USE ONLY

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

Total Income (Children and Adults): $ ____________________ ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly

Eligibility: ☐ Free ☐ Categorically Eligible ☐ Reduced ☐ Paid

Determining Official's Signature: ____ Date: ______________________________

Date Withdrawn: _______________________________

Automated Payment processing
Safe - Convenient - Easy

We are excited to offer the safety, convenience and ease of Tuition Express™ – an automatic payment processing system that allows on-time tuition and fee payments to be made from your bank account.

AUTHORIZATION FOR BANK ACCOUNT ELECTRONIC FUNDS TRANSFER

I (we) hereby authorize Themba Creative Learning Center to initiate debit entries to my (our) Checking or Savings once per ____Week or _____Month (check one option) in the amount of $___________ against the account indicated below. To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice.

Credit Union Members: Please contact your Credit Union to verify account and routing numbers for automatic payments.

Your Name ______________________ Phone # ______________________

Address ______________________ City __________ State __________ Zip __________

Bank or Credit Union Name ______________________

Bank or Credit Union Address ______________________ City __________ State __________ Zip __________

☐ Checking ☐ Savings

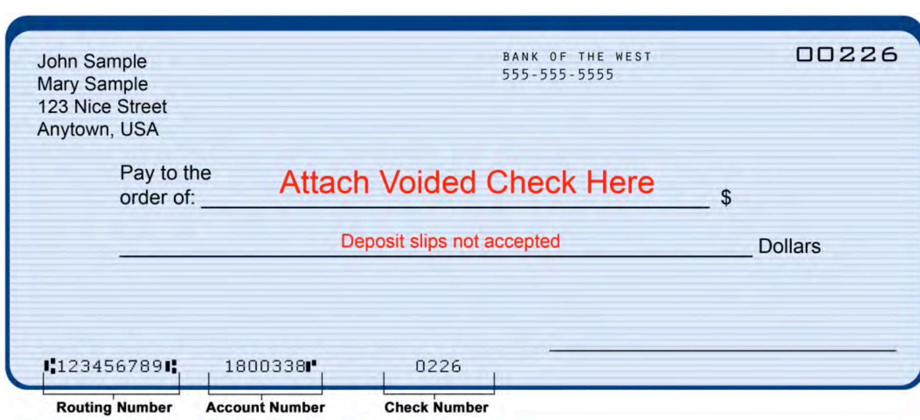
Routing Transit Number (see sample below) ______________________ Account Number (see sample below) ______________________

Signature ______________________ Date ______________________

For Official Use Only...

____
Date Received

____
Employee Signature



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Tuition™ Express

Automated Payment processing
Safe - Convenient - Easy

We are excited to offer the safety, convenience and ease of Tuition Express™ – an automatic payment processing system that allows on-time tuition and fee payments to be made from your bank account.

AUTHORIZATION FOR CREDIT CARD

I (we) hereby authorize Themba Creative Learning Center to initiate recurring credit card charges once per ____Week or _____Month (check one option) in the amount of $___________to the below referenced credit card account. To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice.

Please contact Center Representative for a list of Credit Cards Accepted as Payment.

Cardholder Name | Phone #

Cardholder Address | City | State | Zip

Credit Card Number | Expiration Date

Signature | Today's Date

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For Official Use Only...

Date Received

Employee Signature

- < Cut Here > -

FULL Credit Card Number | Expiration Date | Security Code (3 digits)

For Security, please...

☐ return this Section of the Authorization Form.

☐ Shred this Section of the Authorization Form.

Today's Date