Baldwin Community Center

Baldwin Community Center
After School Program
Registration Form

After Care Program: Please circle days needed:

Monday Tuesday Wednesday Thursday Friday

Approx Pick Up Time:
Notes:

Child's Information:

Child's Name			Date of Birth	Nickname (if any)
Address Street Number/Name				Apartment Number
City / State / Zip			Home Phone	
Grade	Age	Gender	Child lives with (Please circle one) *Mother* *Father* *Both Parents* *Guardian*	
School Attending			Teacher's Name	

Parent / Guardian Information:

Parent / Guardian Name		Parent / Guardian Name	
Address Street Number/Name	Apartment Number	Address Street Number/Name	Apartment Number
City / State / Zip		City / State / Zip	
Home Phone	Cell Phone	Home Phone	Cell Phone
E-mail Address		E-mail Address	
Employer		Employer	
Employer Address		Employer Address	
Employer Phone		Employer Phone	
* Marital Status (Please Circle one): Single Married Separated Divorced		* Marital Status (Please Circle one): Single Married Separated Divorced	

* Maine State Licensing requires a copy of court orders stating that non-custodial parents are not allowed to have contact with or remove their child from the program. Please be sure to give a copy of this to your child's Site Director or Child Care Director so that we have a legal document stating the orders. If we do not have such a copy, we are required by law to release the child to the biological parent regardless of custody. It is our policy not to get involved in custody related services unless required by an official third party.

Additional Information:

Please list any significant factors that may currently be impacting your child (divorce, death in the family or loss of family pet, recently moved or switched schools, a new fear or phobia) that may need special attention or any diagnosed special needs.

Authorization/Release Form

Emergency Contacts / Authorization Pick-Up: <u>At least 3 Contacts/ all fields MUST be completely filled in!</u>

The following people are authorized to pick-up this child and may be contacted in the event of an emergency or illness if the primary parent/ guardian contact can not be reached. Each contact listed will be required to show photo identification when picking up this child.

Name		
Address Street Number/Name		Apartment Number
City / State / Zip		
Home Phone	Work Phone	
Cell / Other Number		
Relationship to Child		

Name		
Address Street Number/Name		Apartment Number
City / State / Zip		
Home Phone	Work Phone	
Cell / Other Number		
Relationship to Child		

Name		
Address Street Number/Name		Apartment Number
City / State / Zip		
Home Phone	Work Phone	
Cell / Other Number		
Relationship to Child		

Name		
Address Street Number/Name		Apartment Number
City / State / Zip		
Home Phone	Work Phone	
Cell / Other Number		
Relationship to Child		

Photo Release

By my signature, I hereby give authorization for the Town of Baldwin to use photos or videos of my child for promotional materials.

Name of Child	Name of Parent / Guardian
Parent / Guardian Signature	Date

By my signature and of my own free will, I do hereby agree to indemnify and save harmless the Town of Baldwin from any and all claims or demands, cost or expenses arising out of any damage sustained to my child or any party I am responsible for.

Parent / Guardian Signature	Date

Medical Authorization

I hereby give authorization to the Town of Baldwin to obtain emergency medical treatment to my child in case of sudden illness or accident.

Child's Name	Parent / Guardian Name
Parent Guardian Signature	**Date**

The State of Maine Childcare Licensing Department requires that every child enrolled has the following information on file. It is important that all information is filled out completely and accurately. If there are any changes to this information during the school year please be sure to give us that information so our files are accurate.

Name of Doctor	Phone
Address Street Number/Name	Apartment Number

Pediatrician (Maine State licensing requires a complete address and phone number):

Immunization Completion Sign-off:

I verify that the child listed below is current with all required immunizations and I have given a copy of this record to his/ her school. (Copy of immunization records not required, but strongly encouraged).

Name of Pediatrician	Parents Signature
Child's Name	Date

Family Dentist (Maine State licensing requires a complete address and phone number):

Name of Dentist	Phone
Address Street Number/Name	Apartment Number

Medical History Form

Child's Last Name: First Name:

MEDICAL HISTORY

Does your child have any chronic or recurring Illness? Please explain.

Does your child have any reactions to insect bites/stings? (if any, how severe is the reaction?)

Does your child have any allergies? Please explain.

Are there any activities your child should be exempt from because of health reasons?

Record of past medical treatment if any:

Does your child have Epilepsy: Yes No
If yes, date of last seizure & severity_____

Does your child have Diabetes: Yes No
If yes, does your child take medications or insulin?

Does your child have Asthma: Yes No
If yes, does your child carry an inhaler?*** Yes No
Does your child carry an epi-pen? *** Yes No

***NOTE:** If you answered yes to any of these questions, please provide a signed note from parent(s) AND the child's physician authorizing your child to self-administer medications if needed.

Will your child be taking medications while in our program? Yes No
NOTE: If yes, an Authorization to Dispense Medication form is required

Hospital Preference:

_____

_____

Medical History Form

SPECIAL NEEDS

Does your child have any known behavior or health concerns? We provide reasonable accommodations to qualified individuals with disabilities. All our participants must be able to participate safely in our programs. We do not provide one on-one supervision and retain the discretion not to enroll or to remove a participant from our program if that participant is not able to participate safely in the program.

HEALTH HISTORY FORM WAIVER

This health history form is correct to the best of my knowledge, and my child herein described has permission to engage in all prescribed camp activities except as noted. I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, treatment, to release any records necessary for insurance purposes, and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization for my child named above.

I understand the Baldwin Community Center does not provide one-on-one supervision.

I understand the Baldwin Community Center retains discretion to remove a child if they are unable to safely participate.

Parent/Guardian Signature: _____

Date:_____