Application for School Age Programs Fall 2019-Spring 2020

Choose from the program options below: (please select as many options as apply)

Enrollment Date (*First date student is to attend program)* ____________________

Before-School Program*

☐ Full-time (10 or more days per month)

☐ Part-time (9 or fewer days per month)

After-School Program

☐ Full-time (10 or more days per month)

☐ Part-time (9 or fewer days per month)

All-Day Programs

☐ All-Day Program Only

☐ Snow Day Program (an additional enrollment fee is required for this program) Limited space available

*Available at limited sites. Check with our office to determine if program is available at your school.

Student's Information:

Student's Last Name ____________________ Student's First Name ____________________ Student's Preferred Name ____________________

Date of Birth ____________ Grade 2019/2020 ____________ School attending 2019/2020 ____________________

Student's address: ____

____

Gender:
☐ Male
☐ Female

Parent or Legal Guardian Contact & Employment Information: (Primary individual responsible for student's account): ☐ Yes ☐ No

Last Name ____________________ First Name ____________________ Last 4 digits of SS#: ____________

Address: (if different from student's address above)

____

____

Relationship with student:
☐ Parent ☐ Foster Parent
☐ Custodial Parent ☐ Legal Guardian

Home Phone:_______/____________ Cell Phone:_______/____________ Cell Provider:____________________ (required for text messaging)

Employer: ____ Work Phone: _______/____________

Daytime e-mail: ____ Work Hours: ____________________

Preferred Method of Contact: ☐ Phone ☐ Email ☐ Text message

Additional Parent Information: (Secondary individual responsible for student's account): ☐Yes ☐No

Last Name ____________________ First Name ____________________ Last 4 digits of SS#: ____________

Address: (if different from other parent's/guardian's address above)

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____

Relationship with student:
☐ Parent ☐ Foster Parent
☐ Custodial Parent ☐ Legal Guardian

Home Phone:__________/__________ Cell Phone:_______/__________ Work Phone:_______/__________

Employer: ____ Work Hours: ____________________

Daytime e-mail: ____

NOTICE: ***Failure to list or disclose complete information will result in student's suspension from the program until complete information is provided to the office.***

Emergency Information: **Other than parents/guardians, in case of emergency, please notify: (this person will also be allowed to pick up your student)**

Name: ____

Cell Phone:________/______________ Other Phone:________/______________ Relationship with Student:__________________

Please list the names of people **other than parents/guardians and the emergency contact person** listed above who are permitted to pick up your student.

Name	Cell Phone Number	Other Phone Number	Relationship with student
	/	/	
	/	/	
	/	/	

Please list any person who is **NOT** allowed to pick up your student. ______________________________

Court documents: (must provide copies of any official court documents) ☐ Custody Orders ☐ Restraining Orders

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Student's Medical and Developmental Information:

Physician's Name______________________ Telephone____________________ Hospital Preference___________________

I give permission for Community Education to administer medication per the instructions listed below. ________________________
Parent/Guardian Signature

List any **medications** your student will receive **during program hours**. Please include the **dosage** of each medication and the **time** that the medicine is to be given by a Community Education staff member. ______________________________

____

List any **medications** your student takes **outside of program hours**. Please include the **dosage** of each medication and the **time** that the medicine is given. ______________________________

____

In planning our programs to meet your student's needs, we must have pertinent information, including any medical, behavioral or cognitive assessments. We also need to be aware of any services provided to your student during the day.

Please check if student has any of the following: (check all that apply)

☐ Diabetes ☐ Frequent colds ☐ Earaches ☐ Developmental delays ☐ Stomach Aches ☐ Epilepsy

☐ High Fevers ☐ Toileting Assistance ☐ Hearing Aid ☐ Special Needs ☐ Physical disabilities

☐ ADHD ☐ Autism ☐ Glasses ☐ Emotional or behavior disorder ☐ IEP or 504 Plan*

☐ Other (specify)________________________ ☐ My student has none of the above symptoms or conditions.

***IEP or 504 Plan:** You must provide a copy of current plan before student can attend the program, so we can provide consistent direction, etc. The current plan is required before the application can be processed. Upon receipt of the current plan, we will evaluate existing staff to determine whether additional training is necessary or additional staff needs to be hired. We will facilitate such measures as quickly as possible. You will be notified when appropriate staffing is in place so that the student can begin attending the program.

List allergies and allergy symptoms:

☐ Asthma ☐ Hay Fever ☐ Hives ☐ Food (please specify) ______________________________

☐ Runny Nose ☐ Watery Eyes ☐ Other (please specify)______________________________

☐ My student has none of the above symptoms or conditions.

NOTE: You must provide Community Education with a doctor's note verifying the condition ***and*** any relevant medication for any medical condition requiring accommodations or treatment (alternate snack due to food allergies, EpiPen, other medication, etc.) ***before*** your student may start in the program.

Print Student's Full Name: ______________________________

Print Student's Birthdate: ______________

1. All the information on this application is completed accurately. I know that complete and accurate information is necessary to best serve my student. I understand that it is my responsibility to notify Community Education of any changes in employment, residence, phone numbers and any emergency information that may change.

   ______________ Initials*

2. I hereby authorize Community Education to seek medical treatment for my student in the event of an emergency, including transportation by ambulance to the nearest hospital. ***I understand that I am solely responsible for any medical expenses including ambulance transportation***, which my student may incur for any injuries, including those resulting from on-site injuries or off-site on an approved field trip. I hereby release Community Education from any and all claims or causes of action for any injuries sustained by my student at the program.

   ______________ Initials*

3. I give permission for my student to participate in Community Education field trips, whether by walking a short distance or being transported from the program on field trips, outings or other center-sponsored activities. I hereby release Community Education from any and all claims or causes of action for any injuries sustained by my student in being transported to or from school. A separate, signed permission slip is needed for all trips.

   ______________ Initials*

4. I understand that a copy of Community Education's Parent Handbook is readily available online at www.commed.us and I will review and abide by the provisions therein. I also understand that a hard copy is available by request at the Community Education office. Once my application has been processed, a copy of the site-specific disaster plan will be available for viewing on MyProcare Parent Portal account.

   ______________ Initials

5. *Optional* - I give my student permission to watch only G rated movies during program hours.

   ______________ Initials*

6. *Optional* - I give my student permission to watch both G and PG rated movies during program hours.

   ______________ Initials*

7. *Optional*—Occasionally a newspaper, Western Kentucky University, or television station visits to promote student's activities. Community Education has a website, Facebook, Instagram, and Twitter pages where we occasionally post photos of students engaged in educational programs. I agree to allow my student to participate in these activities.

   ______________ Initials*

NOTE: Participation in Community Education programming is voluntary. Only students whose parents/guardians have agreed to sections 1-4 will be accepted into the programs. Section 5-7 are optional.

Check applicable box:

☐ I am this student's parent.

☐ I am this student's legal guardian.

☐ I am this student's foster parent.

____
Print Your Name

______________________________ ______________________
Complete Signature* Date

*My initials on this page represent my legal signature and constitute a legal agreement.

Form revised 4 / 1 9

This page will be kept confidentially at the Community Education office at 1227 Westen St.
It does NOT go to the program site.

ACCOUNT INFORMATION 2019/2020:

STUDENT'S NAME: ______________________________

ADULT RESPONSIBLE FOR ACCOUNT: ______________________________

SOCIAL SECURITY NUMBER: ______________________________
(of adult responsible for account)

VALID EMAIL ADDRESS: ______________________________
(for billing and direct communication purposes only)

FULL-TIME ENROLLMENT: To provide quality care at a reasonable cost, Community Education School Age Program enrollment consists of the purchase of a position. Tuition is calculated on an annual basis. It is not to be considered hourly, weekly or even monthly care. However, in order to be consistent, we divide the program into equal monthly payments for full-time care. Full-time tuition is to be paid every month, regardless of the number of days school is in session or number of days attended.

I understand that full-time fees are due the 1st of each month, regardless of whether school is in session, and a late fee of $20 will be assessed after the 6th of each month.

PART-TIME ENROLLMENT: I understand that part-time fees are due upon receipt and a late fee of $20 will be added to my account after the 20th of each month. In order to keep your account active, a minimum monthly fee equal to one day's charge will be charged to your account regardless of whether your student attended the program that month. Please see the Parent Handbook for additional billing details.

I also understand that part-time invoices are e-mailed monthly and that it is my responsibility to maintain an accurate email address with the Community Education office staff to ensure the receipt of my monthly invoice.

DELINQUENT ACCOUNTS: I understand that my student's enrollment will be terminated and my account turned over for collection if it is in default. I will be responsible for all costs related to collection, including legal fees. My signature below indicates that I agree to reimburse Community Education the collection fees of any collection agency, which shall be based on a percentage at a maximum rate of 33 1/3% of the amount due at the time my account is placed with a collection agency, and all costs and expenses incurred for any collection efforts on my account, including reasonable attorney's fees incurred by the collection agency. This contract shall cover all services until revoked by either party in writing.

I understand that I am responsible for the balance of my account, even if I am receiving financial assistance and if for any reason subsidy programs do not pay the agreed amount on my account.

SIGNATURE OF ADULT RESPONSIBLE FOR ACCOUNT: ______________________________*
*My signature on this page constitutes a legal agreement.

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FOR OFFICE USE ONLY

DATE PAYMENT RECEIVED ______________________________

PAYMENT METHOD: ☐ CASH ☐ CREDIT CARD ☐ CHECK #: ______________

PAYMENT AMOUNT: ______________________________

PAYMENT FOR: ☐ ENROLLMENT FEE ☐ ENROLLMENT WITH SIBLING

☐ MONTHLY FEE ☐ MONTHLY FEE PRORATED

☐ OTHER ______________________________

FAXED TO SCHOOL:______________________________

Bowling Green – Warren County
Community Education

Consent to Release Education Records

RE: ____

Print Student's Full Name

____

Student's Date of Birth

Community Education works with the school districts to provide consistent direction for students.

I hereby authorize Bowling Green – Warren County Community Education and any school district or educational agency in which my above-named student is or has been enrolled to release and/or provide to each other copies of all my student's records in each entity's possession. This authorization includes my consent to release to the school district in which my child is or will be enrolled and to Bowling Green – Warren County Community Education any and all of my student's education records which would otherwise be protected from disclosure under the Family Educational Rights and Privacy Act, 20 U.S.C. §1232, and the Kentucky Family Education Rights and Privacy Act, KRS 160.700-160.990. I acknowledge my signature (electronically or otherwise) in this agreement constitutes my legal, binding signature. By signing my full name below, I confirm that I am the appropriate legal party to sign this agreement, and I am the person who is signing below and authorizing release.

______________________________________ ________________________

Signature of Parent or Guardian Date

____

Print Name of Parent or Guardian

Check applicable box for person signing above:

❑ Parent

❑ Guardian

Note: Only students whose parents/guardians have agreed to this consent will be accepted into the programs.