PARENTAL EMERGENCY MEDICAL CONSENT

This form must be presented upon admission for treatment

Child's Full Name _____ Date of Birth _____ .

This form allows parents and guardians to authorize the provision of emergency treatment for above named child who becomes ill or injured while under program authority when parents or guardians cannot be reached.

In the event reasonable attempts have been made to contact me at _____ (phone number) or _____ (phone number) have been unsuccessful, I hereby give consent for the administration of any treatment necessary by Doctor _____ (physician) at _____ (phone number) or Doctor_____ (dentist) at _____ (phone number), or in the event the designated practitioners are not available, then by another licensed physician or dentist; and the transfer of the child to _____ (preferred hospital).

1. Parents/Guardians/Custodians with Whom the Child Resides:

Name _____ Relationship to Child _____ .
Address _____ Home Phone _____ Cell Phone _____ .
Employer _____ Department _____ .
Work Phone _____ Work Hours _____ .

Name _____ Relationship to Child _____ .
Address _____ Home Phone _____ Cell Phone _____ .
Employer _____ Department _____ .
Work Phone _____ Work Hours _____ .

2. Persons to Contact in Case of Emergency if Parents are Unavailable, and are Authorized to Pick Up the Child:

Name _____ Relationship to Child _____ .
Address _____ Home Phone _____ Cell Phone _____ .
Employer _____ Department _____ .
Work Phone _____ Work Hours _____ .

Name _____ Relationship to Child _____ .
Address _____ Home Phone _____ Cell Phone _____ .
Employer _____ Department _____ .
Work Phone _____ Work Hours _____ .

3. Are there any custody or restraining orders for person(s) who may attempt to pick up or have contact with the child while in care at the center:

Name _____ .
Name _____ .

4. Information:

Physician Name _____ Dentist Name _____
Street Address _____ Street Address _____
City, State _____ City, State _____
Phone # _____ Phone # _____

Date of Last Tetanus _____ Known Allergies _____ .
Present Medication _____ .
Insurance Company _____ Policy Holders I.D. _____ .
This consent will be in effect beginning (date) _____ and will be valid for one update.

Signature of Parent/Guardian _____ Date _____ .
Updated Signature of Parent/Guardian _____ Date _____ .

Each signature is valid for 1 year only To update please initial and date all signatures.
New forms are required after 2 years

RELEASE AUTHORIZATIONS

Shimek Before and After School Program

TRAVEL RELEASE

I/We do ☐, do not ☐, give consent for _____ (child's name) to participate in field trips with the above named program. I/We do reserve the right to be notified before each field trip that involves travel out of town. I release the program of any liability unless negligence is proven.

Restrictions:

Date _____ Signature of Parent/Legal Guardian _____.

PHOTOGRAPHY/VIDEO TAPING RELEASE

I/We do ☐, do not ☐, give consent that the above named program may take photographs/video tapings of our child, _____ (name of child) and I/we consent that the program may use the photographs/video tapes of our child in promoting the purpose of the Center. We understand that no financial benefits from the use of the photographs/video tapes are obligated to be paid to us.

Restrictions:

Date _____ Signature of Parent/Legal Guardian _____.

PERMISSION FOR GIVING SUNSCREEN AND ANTIBIOTIC OINTMENT

Shimek BASP (child care provider) has my permission to give _____ the following on an "as needed" basis. (Child's Name)

Sunscreen ☐

_____

Applied to exposed skin, except eyelids, before exposure to the sun.
Apply according to instructions provided by the manufacturer.

Triple Antibiotic Ointment ☐

_____

To be applied to scrapes and wounds when administering First Aid, according to the instructions provided by the manufacturer.

Additional Instructions_____

Parent/Guardian signature _____**Date** _____

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SHIMEK BASP
FINANCIAL/TUITION AGREEMENT
FOR THE FAMILY OF

_____

I understand that I owe _____ to Shimek BASP by the first day of each month. If our tuition is not paid by the eighth of each month, I will be charged a late fee of $5.00. If the tuition is not paide by the 15th of each month my child may be discharged from the program at the discretion of the board.

I understand that I will be charged a late fee if my child(ren) are not picked up by 5:45pm. Late fee charges begin at 5:45pm and if they are not picked up by this time the late fees are $1.00 per minute per family.

I understand that I must give 30 days written notice before leaving the program.

I understand and agree to these terms.

_____

(signature and date)

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SCHOOL-AGE ASSESSMENT & HEALTH FORM
& IMMUNIZATION DECLARATION

A. **HEALTH STATEMENT** – To be completed by the parent.

_____

Child's Full Name Birth Date

1. Significant illnesses and surgeries child has had (give age at time):

_____
_____

2. Any special health-related needs of child (allergies, medications, injuries, etc.):

_____
_____

B. **PHYSICAL ASSESSMENT**

1. Is there any defect of vision, hearing or speech of which the child care program should be aware, or could compensate by appropriate action?

_____
_____

2. Is this child subject to any conditions which limit classroom activities or physical education?

_____
_____

3. Is this child subject to any condition which may result in an emergency situation?

_____
_____

4. Is this child subject to any mental or physical condition for which he/she should remain under periodic medical observation?

_____
_____

5. Other information you would like to share:

_____
_____

FOR CENTERS SERVING SCHOOL-AGE CHILDREN OPERATING IN THE SAME SCHOOL FACILITY IN WHICH THE CHILD ATTENDS SCHOOL:

My signature below certifies that immunization information concerning my child has been provided and is available in the school file.

Parent's Signature _____ Date _____

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New forms are required after 2 years

ARRIVAL/DEPARTURE—ADDITIONAL INFORMATION

Name of child: _____

MORNING ARRIVAL:

Sign one:

☐ My child will arrive in the morning, and be checked in accompanied by a parent or responsible adult listed.

Signature of parent/guardian: _____

☐ My child will arrive and check in to the morning session on his/her own, without an accompanying adult. I realize that the program is not responsible for the child until he/she has entered the program premises. I realize that she/he must be on time (as listed on the Arrival/Departure procedures form); if not, the director may spend attention searching for a child presumed missing. I realize it is difficult to contact parents who are usually en route to their jobs, and that the Program is not actually required to notify parents of a missing child.

Signature of parent/guardian: _____

AFTERNOON DEPARTURE:

Sign one:

☐ My child will check out and leave the program accompanied by a parent or responsible adult listed.

Signature of parent/guardian: _____

Signature of accompanying adult: _____

☐ My child will check out and leave the program on his/her own. I realize that the Program is not responsible for the child once he/she has exited the door of the supervised program premises.

Signature of parent/guardian: _____

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INTAKE SHEET

A. Child's Identification Information:

Name:	Nickname:
Address:	Phone:

Sex:	Birthdate:	Grade:	Teacher (if known):

B. Family Information: Parents or Guardians:

Name Address Place of Employment Work Phone

_____

_____

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Foster Parent

Names and ages of other children in the home:

_____ _____

_____ _____

_____ _____

C. Child's Medical History:

- Allergies (goods, medications, bees, etc.) _____
- Chronic or recurrent illnesses or diseases (asthma, seizures, diabetes, etc.) _____

(please write "none" if your child has no medical problems)

Does your child take medication for this condition? ☐ Yes ☐ No

If yes, please state the name and dosage _____

Will the medication need to be given during program hours? ☐ Yes ☐ No

If yes, when and how is it to be given? _____

What should we do if your child has a problem related to her/his medical condition during program hours? _____

_____

_____

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D. Play and Sociability:

- How does your child get along with other children? _____

_____

- His/Her usual playmates are ☐ girls ☐ boys ☐ older ☐ younger
- What is the usual size of your child's neighborhood playgroup? _____
- Previous group experience other than school:

☐ Preschool ☐ Playgroup ☐ Sunday School

☐ Other (Specify) _____

E. **Personality and Emotional Development**

- Is your child affectionate? _____ To whom? _____
- Does she/he accept new people easily? ☐ Yes ☐ No
- What are your child's fears? _____
- Is your child usually happy? ☐ Yes ☐ No
- What nervous habits does your child have?
  _____

F. **Discipline**

- When you find it necessary to punish your child, which parent usually does this and how?_____
  _____
  _____

G. **Other Information: Please list some of your child's favorite:**

- Snacks and drinks: _____
- Games: _____
- Other Activities: _____
- Give any further information that would be helpful in understanding your child or would enhance your child's experience in our program.
  _____
  _____
  _____

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ATTACHMENT D

Consent to Release and Exchange of Information

A copy of this form is considered as valid as the original. The Contact Person will send copies of this form to all individuals/agencies listed below. Individuals/agencies listed are responsible for providing requested information.

We want to protect student and family confidentiality, while complying with both state and federal law, including but not limited to the Privacy Act of 1974, specifically the Family Educational Rights and Privacy Act (FERPA.) By signing this form, you are giving permission to the individual(s)/organization(s)/agency(ies) listed below to share information which would otherwise be confidential.

- Child/Student_____ Birth date_____
  (Legal Last Name) (First) (MI) (Mo Day Yr)

  I give permission for the parties named below to release and receive written and verbal information regarding the above named child/student for the purpose of the release and exchange of educational records and program information to coordinate after school activities with the school day.

- I understand that I may revoke permission by giving written notice to each party named below. I understand
  Matthew Larson
  (Contact Person)
  Shimek Before and After School Program (Shimek BASP) (319) 530-1413
  (Position/Agency) (Phone #)
  can direct me to the shared information upon request.

- The following agencies and organizations will collaborate with one another in planning, coordinating, and delivering services to students receiving services under the program, Shimek BASP being administered by the Iowa City Community School District. Therefore, this form permits the use, disclosure and redisclosure of confidential information for the purpose stated above and delivery of said services.

  I understand that state and federal law prohibits persons that receive mental health, alcohol or drug abuse, and educational records from redisclosing those records without permission. I also understand that not every organization that may receive a record is required to follow federal HIPAA rules governing the use and disclosure of protected health information. [HIPAA is a federal law intended to protect confidentiality of health care information.]

  I HEREBY GIVE PERMISSION TO THE PERSON(S), AGENCY(IES), AND ORGANIZATION(S) THAT RECEIVE RECORDS PURSUANT TO THIS AUTHORIZATION TO RELEASE AND REDISCLOSE THAT RECORD AND THE INFORMATION IN THAT RECORD TO OTHER PERSONS, ORGANIZATIONS, OR AGENCIES LISTED HEREIN FOR THE PURPOSES OUTLINED ABOVE, BUT FOR NO OTHER PURPOSE WHATSOEVER.

1. ICCSD (319)688-1000
   Name of Individual and/or Position and Agency Phone

   Address: 1725 N. Dodge St. Iowa City, IA, 52245

   Info to share: _____

2. Shimek BASP (319)530-1413
   Name of Individual and/or Position and Agency Phone

   Address: 1400 Grissell Pl. Iowa City, IA, 52245

   Info to share: _____

ATTACHMENT D

3. _____
Name of Individual and/or Position and Agency Phone

Address: _____

Info to share: _____

4. _____
Name of Individual and/or Position and Agency Phone

Address: _____

Info to share: _____

- I understand that this permission and release is valid for one year following its execution, and that this permission and release will **expire one year from today's date**. I understand that this permission and release may be revoked. I understand that if this permission is revoked, it may not be possible to continue to participate in certain programs. I will be informed of that possibility if I wish to revoke this permission. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person, agency, or organization that relied on this permission may continue to use records and protected information as needed to complete work that began prior to the revocation of this permission.

Signature_____ Date:_____
Parent/Legal Guardian

Signature_____ Date:_____
Student

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW:
My signature authorizes release of all information relating to (check appropriate boxes):

☐ Mental Health/Psychological ☐ Substance Abuse ☐ HIV Status/AIDS related testing

☐ Other (specify)_____

- Signature _____ Parent/Legal Guardian Date
- Signature _____ Student Date

- Witness _____ Date: _____
Name of Individual and/or Position and Agency

BASP Student Demographic Information Form

This information is voluntary and being requested to ensure all programs using District buildings are serving all students and their diverse needs. The Iowa City Community School District has a non-discrimination policy to ensure students are not discriminated against in educational programs and activities.

Student's Name:_____Date:_____

Please fill out the information below by placing an "X" next to the appropriate field:

Funding	Yes	No
Private Pay	☐	☐
Student receives Childcare Assistance (CCA)	☐	☐
Students receives 21st CCLC Funding	☐	☐
Students receives Bridge Care Funding	☐	☐

Students by Special Services	Yes	No
Student has a Disability	☐	☐
Student is Free/Reduced Lunch	☐	☐
Student has Limited English Proficiency (optional)	☐	☐

Gender	
Female	☐
Male	☐

Race/Ethnicity	
(A)Asian	☐
(B)Black or African American	☐
(I)American Indian or Alaska Native	☐
(P)Native Hawaiian/other Pacific Islander	☐
(W)White	☐
(H)Hispanic/Latino	☐

Parent/Guardian Signature_____