Camp Fire Western Montana Enrollment Form

* Please complete one form for each child

Start date:_____ School:_____

Child's name:_____ Birth Date:_____

Sex: M F Age: _____ Grade: _____

Parent/Guardian Name: _____ **Employer:** _____

Home address: _____ City:_____ Zip:_____

Home #:_____ Work #:_____ Cell #:_____

Parent/Guardian Name: _____ **Employer:** _____

Home address: _____ City:_____ Zip:_____

Home #:_____ Work #:_____ Cell #:_____

Child Lives With: Mother Father Both Other_____

*** If neither parent/guardian can be contacted, please call:**

Name:_____ Home #:_____ Work #:_____
(relationship)

Name:_____ Home #:_____ Work #:_____
(relationship)

In an emergency, Camp Fire has my permission to call an ambulance at my expense: Yes No

Does your child have a religious or medical exemption for immunizations? Yes No

I give permission for my child to be photographed for marketing and advertising purposes: Yes No

Does your child have any allergies? (Please be specific)

_____

Does your child have any special needs?(If so, please complete the Special Needs Health Care Plan form)

_____

I have read all the Camp Fire policies regarding the program(s) I am enrolling in and I agree to take fiscal responsibility for the child named above.

Parent/Guardian Signature_____ Date_____

Office Use Only: Fee Paid: _____ Immunization Record Received: _____

CAMP FIRE AFTER SCHOOL KID'S CLUB
ATTENDANCE AND TUITION CONTRACT

The Camp Fire Kid's Club runs from dismissal to 6:00p.m. Monday through Friday on all full days of school. Late pick-ups will result in additional charges.

Please choose an attendance option for the school year. Rates of tuition depend on the number of days per week of care. Additional children in the family may be added at a discount. Additional days may be added at the rate of $14/day ($12/day for sibling), and depend on availability of space.

Credit will not be given for missed days.

You will receive an invoice every month for the amount due. Invoicing is done on the 15th of each month and payment is due by the 1st of each month. Failure to pay by the 1st of the month will result in suspension of services until payment is made.

All schedule changes must be made 2 weeks in advance and must include a signed, updated tuition contract.

Please select the attendance option and days of the week your child will attend Camp Fire.

CHILDS NAME _____

SCHOOL_____

☐	**5 days**	**M** ☐	**T** ☐	**W** ☐	**TH** ☐	**F** ☐	**$280/ month ($250 for sibling)**
☐	**4 days**	**M** ☐	**T** ☐	**W** ☐	**TH** ☐	**F** ☐	**$230/ month ($200 for sibling)**
☐	**3 days**	**M** ☐	**T** ☐	**W** ☐	**TH** ☐	**F** ☐	**$170/ month ($150 for sibling)**
☐	**2 days**	**M** ☐	**T** ☐	**W** ☐	**TH** ☐	**F** ☐	**$120/ month ($100 for sibling)**

All billing, payment collection, schedule changes and administrative or program concerns should be directed to our main office at 2700 Clark Street, 542-2129.

I have read and agree to this contract.

Signature_____ Date_____

ASSUMPTION OF RISK AND WAIVER OF LIABILITY
AND MEDICAL AUTHORIZATION

As a legal guardian of _____, I recognize that potentially severe injuries can occur in sports or activities including but not limited to, ropes courses, team sports, swimming and boating. Being fully aware of these dangers, I voluntarily consent to the aforementioned person participating in any and all Camp Fire Western Montana programs, camps and activities and I accept all risks associated with that participation.

I, on my own behalf and the behalf of my child and our respective heirs, administrators, executors and successors, hereby covenant not to sue and forever release Camp Fire Western Montana, Ponderosa Council, its officers, directors, employees or agents from all liability for any and all damages or injuries suffered by my child while under supervision or control of Camp Fire Western Montana, Ponderosa Council.

In the event of an accident or emergency I would like my above mentioned child to be taken to the hospital for medical treatment and I hold Camp Fire Western Montana, Ponderosa Council harmless in their execution of this action. I hereby agree to individually provide for all possible future medical expenses, which may be incurred by my child as a result of any injury sustained while participating in any Camp Fire Western Montana, Ponderosa Council program or activity.

I give permission for publicity use of any photos taken at any and all Camp Fire programming or events. Finally I hold Camp Fire Western Montana, Ponderosa Council harmless for loss or theft of personal items taken to any Camp Fire Western Montana, Ponderosa Council program or activity.

I have read and understood this assumption of risk and waiver of liability and medical authorization and I voluntarily affix my name in agreement. Signed and dated by parent or legal guardian.

Signature: _____

Date: _____

Camp Fire

Light the fire within

DPHHS-QAD/CCL-113
(Revision 7-2006)

State of Montana
Department of Public Health and Human Services
Quality Assurance Division – Licensure Bureau
Child Care Licensing

EMERGENCY CONTACT AND PARENTAL CONSENT

THIS FORM MUST BE TAKEN WITH THE CHILD WHEN EMERGENCY MEDICAL CARE IS NEEDED.

Child's Name: _____ **Birth Date:** _____

Address: _____

Mother / Legal Guardian's Name: _____ **Home Number:** _____

Address: _____ **Cell Number:** _____

Work Address: _____ **Work Number:** _____

Father / Legal Guardian's Name: _____ **Home Number:** _____

Address: _____ **Cell Number:** _____

Work Address: _____ **Work Number:** _____

Emergency Contact Person: _____ **Contact Number:** _____

Emergency Contact Person: _____ **Contact Number:** _____

Physician / Medical Care Source: _____ **Contact Number:** _____

Health Insurance Carrier & Policy Number: _____

Persons authorized to pick up child:

Name: _____ **Name:** _____

Name: _____ **Name:** _____

– CONTINUED –

WRITTEN CONSENT IS GIVEN FOR:

☐ **Yes** ☐ **No** EMERGENCY MEDICAL CARE

☐ ADMINISTRATION OF PRESCRIPTION MEDICATIONS **Medication Authorization form and Medication Administration Log Must be completed**

☐ ADMINISTRATION OF NON-PRESCRIPTION MEDICATIONS **OTC Medication Authorization Form and Medication Administration Log must be completed**

☐ ADMINISTRATION OF SPECIAL DENTAL OR DIETARY NEEDS:
Please Specify:

☐ TRIPS: ☐ **Yes** ☐ **No** TRANSPORTATION BY THE FACILITY FOR TRIPS

☐ **Yes** ☐ **No** DAILY TRANSPORTATION PROVIDED BY THE FACILITY (Facility Has the Option to Offer)

IF YOUR CHILD IS TRANSPORTED BY THE FACILITY, ARE THERE ANY INSTRUCTIONS FOR SPECIAL CARE FOR THE CHILD (I.E. MOTION SICKNESS, SEIZURES, ETC.) DURING TRANSPORTATION?

HEALTH HISTORY

	YES	NO		YES	NO
Hay fever, asthma, or wheezing	☐	☐	Chickenpox	☐	☐
Eczema or frequent skin rashes	☐	☐	Diabetes	☐	☐
Convulsions/Seizures	☐	☐	Trouble with passing urine / bowel movement	☐	☐
Heart condition	☐	☐	Frequent colds, sore throats, earaches, tonsillitis, pneumonia	☐	☐

	YES	NO
Allergies or reaction: (food or other)	☐	☐

Please Explain:

	YES	NO
Other Health Concerns (special disabilities):	☐	☐

Please Explain:

SIGNATURE OF PARENT OR GUARDIAN **DATE**

DPHHS-QAD/CCL-120
(Revision 06-07)

NON-INGESTIBLE OVER THE COUNTER (OTC) MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT

Child's Name_____Date of Birth_____/____/___
Program Name_____Today's Date_____/____/___

****

I give permission for the administration of following non-ingestible over the counter medications (mark all that apply):

☐ Diaper Rash Cream/Ointments

☐ Insect Repellent

☒ Sunscreen

☐ Cortisone/Anti-Itch Creams/Ointments

☐ Medicated Lip Treatments

☒ OTC Antibiotic Creams/Ointments

☐ Burn Creams/Sprays

☐ Other Non-Ingestible OTC's: (Please Specify)_____

☐ _____
☐ _____
☐ _____

To administer a non-ingestible over the counter (OTC) medication:

- The OTC medication must be brought to the day care facility from the parent;
- The OTC medication must be in its original container, with a legible label, and expiration date of medication;
- The child's name must be on the original container

Special handling/storage Instructions_____Refrigeration Y/N

Parent/Guardian Signature (required)_____

*** This document must be updated on an annual basis.**

Unused Medication: Returned to Parent Y/N or Discarded Appropriately (circle one)

By: _____ Date _____/_____/_____

***Keep in the child's file when medication is finished**.