HOME AWAY FROM HOME FRA CHILD CARE PROGRAM APPLICATION FROM ADMISSIONS

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| --- | --- |
| Child’s Name: |  |
| Address: |  |
|  |  |
| Birth Date: |  |
| Current Age: |  |

|  |  |
| --- | --- |
| Health Card #: |  |
| Family Dr: |  |
| Family Dr. #: |  |
| Family Dr Address: |  |
|  |  |
| Allergies: |  |

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| --- | --- |
| Care Required: | Afterschool \_\_\_\_\_\_ |
| Days Care is Needed: | Monday \_\_\_\_\_\_ Tuesday \_\_\_\_\_\_ Wednesday \_\_\_\_\_\_  Thursday \_\_\_\_\_\_ Friday \_\_\_\_\_\_\_ |
| Hours Reguired: | am - pm |

|  |  |
| --- | --- |
| Mother’s Name: |  |
| Address: |  |
|  |  |
| Contact #: |  |
| Work #: |  |
| Email Address: |  |

|  |  |
| --- | --- |
| Father’s Name: |  |
| Address: |  |
|  |  |
| Contact #: |  |
| Work #: |  |
| Email Address: |  |

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| --- | --- |
| Emergency Contact: |  |
| Relationship to Child: |  |
| Address: |  |
|  |  |
| Contact #: |  |
| Work #: |  |

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| --- | --- |
| Persons for Pick Up:  (name & relationship) |  |

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| --- | --- |
| Helpful Information to get to know Your Child: |  |

IMMUNIZATIONS:

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| --- | --- | --- |
| **Immunization** |  | **Date Received** |
| 2 mons | DaPTP, Hib |  |
| 4 mons | DaPTP, Hib |  |
| 6 mons | DaPTP, Hib |  |
| 12 moons | MMR |  |
| 18 mons | DaPTP, Hib |  |
| 4-6 years | DaPTP, MMR |  |
| 12+ mons | Varicella |  |

|  |  |
| --- | --- |
| Has your child had any reactions to his/her needles? Please explain: |  |

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| --- | --- |
| Parent’s Signature: |  |
| Date: |  |

|  |  |
| --- | --- |
| Program Staff Signature: |  |
| Date: |  |

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| --- | --- |
| Start Date: |  |
| Withdrawal Date: |  |

**PARENT CONTRACT**

Upon enrolling my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, I agree to:

**DAYS FOR CARE:**

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| I need care for the following days and hours of care for my child(ren):   * Monday Hours: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Tuesday Hours: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Wednesday Hours: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Thursday Hours: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Friday Hours: \_\_\_\_\_\_\_\_\_\_\_\_\_\_   **Parent Initials: \_\_\_\_\_\_\_\_** |

**PAYMENT:**

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| I agree to pay for child care services on a schedule agreement between myself and the program director.  **Parent Initials: \_\_\_\_\_\_\_\_** |
| I understand failure to pay for my child care will result in the loss of my child care placement or be required to pay in advance for my child care needs.  **Parent Initials: \_\_\_\_\_\_\_\_** |
| I understand that there will be a late fee for late pick up and/or late payments. Late pick up fees are paid directly to the care provider at the time of pick up.  **Parent Initials: \_\_\_\_\_\_\_\_** |
| I understand that I am obligated to pay for all scheduled days including sick and storm days, should the provider remain open.  **Parent Initials: \_\_\_\_\_\_\_\_** |

**WITHDRAWAL:**

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| When withdrawing from the FRA After school Program, I will give two weeks written notice to the Director OR pay for two weeks of child care.  **Parent Initials: \_\_\_\_\_\_\_\_** |

**PERSONAL INFORMATION:**

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| I allow Home Away From Home FRA Child Care Program to collect, use and disclose personal information in order to:   * Provide the best care possible, adequately meeting the needs of my child and my family * Meet the Legislative requirements of the Day Care Act and Day Care Regulations   **Parent Initials: \_\_\_\_\_\_\_\_** |

**PHOTOGRAPHING:**

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| I allow my child to be photographed for program displays and/or media exposure.  **Parent Initials: \_\_\_\_\_\_\_\_** |

**ILLNESS:**

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| If at the in after school program, my child becomes ill, I authorize my care provider or an Agent for Home Away From Home to provide consent for treatment at the local hospital Roseway, or Yarmouth).  **Parent Initials: \_\_\_\_\_\_\_\_** |
| Should an ambulance needed to be called in an emergency situation, I understand that I am responsible to pay for any costs incurred.  **Parent Initials: \_\_\_\_\_\_\_\_** |

**OUTINGS:**

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| I give permission for my child to participate in outings throughout the year. I understand that the children will be accompanied by their child care provider and every consideration will be taken for their safety.  **Parent Initials: \_\_\_\_\_\_\_\_** |

**PARENT HANDBOOK:**

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| I have received a copy of the parent handbook provided by my care provider.  **Parent Initials: \_\_\_\_\_\_\_\_** |

**PROMISE OF CONFIDENTIALITY:**

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| As a parent of a child in an approved home through Home Away From Home Family Day Care Agency, I will not disclose any information made known to me from the care provider. I understand that should I breach this confidentiality, I may be asked to remove my child from the approved in home day care.  **Parent Initials: \_\_\_\_\_\_\_\_** |

**LIABILITY:**

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| --- |
| I hereby release the Home Away From Home FRA Child Care Program, it’s agents and employees from any and all liabilities for any person or consequential injury or illness occurring to my child(ren) while he/she/they are in the care of the agency, its agency and employees wile my child(ren) are in the Home Away From Home FRA Child Care Program.  **Parent Initials: \_\_\_\_\_\_\_\_** |

Parent Signature : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Care Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_