

ADDITIONAL INFORMATION

Child's Physician: _____

Address: _____ Phone: _____

Allergies: _____ Reaction: _____

Treatment: _____

Special Diet: _____

Chronic Health Conditions: No _____ Yes _____

If yes to chronic health conditions, must attach copy of Individual Health Plan from child's physician

Does child take daily medication: No _____

Yes _____ *

***Please list all daily medication, doses and times given:**

Is your child on an IEP? No _____ Yes _____ *(Must attach a copy of the most recent one)*

Special limitations or concerns: _____

Copies of any custody agreements, court orders, restraining orders pertaining to your child?

NO _____ Yes _____ *(Please attach)*

I certify that documentation of physical examination and immunizations in accordance with public school health requirements, and lead poisoning screening in accordance with public health care requirements are on file at the Orleans Elementary School, 46 Eldredge Parkway, Orleans, MA 02653.

Parent/Guardian initials _____

Parent/Guardian Signature

Date

**ORLEANS AFTER SCHOOL ACTIVITIES PROGRAM
FIRST AID AND EMERGENCY MEDICAL CONSENT FORM 102CMR7.09(3)**

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

I authorize staff in the child care program who are trained in the basics of first aid/CPR to give my child first aid/CPR when appropriate. I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical facility and/or to _____, and to secure necessary medical treatment for my child.

Child's Physician Name: _____

Address: _____

Phone number: _____

Child's Allergies: _____

Chronic Health Conditions: _____

Parent/Guardian Name _____

Phone (H): _____ **Phone(W):** _____ **Cell:** _____

Parent/Guardian Name _____

Phone (H): _____ **Phone(W):** _____ **Cell:** _____

EMERGENCY CONTACTS (IN ORDER TO BE CONTACTED IF PARENTS CANNOT BE REACHED)

1. Name: _____ **Relationship to child:** _____

Address: _____

Home Phone: _____ **Cell Phone:** _____

Do you give permission for child to be released to this person Yes _____ No _____

2. Name: _____ **Relationship to child:** _____

Address: _____

Home Phone: _____ **Cell Phone:** _____

Do you give permission for child to be released to this person Yes _____ No _____

3. Name _____ **Relationship to child:** _____

Address: _____

Home Phone: _____ **Cell Phone:** _____

Do you give permission for child to be released to this person Yes _____ No _____

Health Insurance Coverage: _____ **Policy #:** _____

***Parent/Guardian Signature** _____ **Date:** _____

ORLEANS AFTER SCHOOL ACTIVITIES PROGRAM

P.O. Box 2063
Orleans, MA 02653
508-255-0380, **ext 227**

GENERAL CONSENT FORM

Child's Name _____ Date of Birth _____

COMMUNICATION WITH ORLEANS / NAUSET SCHOOL SYSTEM

I give permission to OASAP, Inc. to communicate with any and all personnel (i.e. Secretary, Nurse, Guidance Counselor, Teacher, Principal) of the Orleans and Nauset Regional School System regarding the needs of my child. I understand that all communications will be confidential.

Parent / Guardian Signature _____ **Date** _____

PHOTO PERMISSION

I give permission for OASAP, Inc. to photograph my child while attending the program. Photographs will be used for OASAP website, projects, scrapbooks, OASAP newsletters and slideshows.

_____ I give permission for my child to be photographed while attending the OASAP Program.

_____ I do not give permission for my child to be photographed while attending the OASAP Program.

Parent / Guardian Signature _____ **Date** _____

**ORLEANS AFTER SCHOOL ACTIVITIES PROGRAM
TRANSPORTATION PLAN AND AUTHORIZATION**

Child's Name: _____

MY CHILD WILL ARRIVE AT THE PROGRAM BY:

- _____ parent drop off
- _____ supervised walk
- _____ unsupervised walk from classroom
- _____ school bus
- _____ private transport / arranged by parent
- _____ other

MY CHILD WILL DEPART FROM THE PROGRAM BY:

- _____ parent / designee from emergency contact form pick up
- _____ supervised walk
- _____ unsupervised walk
- _____ private transportation / arranged by parent
- _____ other

Any other transportation authorizations must be in writing and will be maintained in your child's file.

Parent/Guardian Signature _____ **Date** _____

ORLEANS AFTER SCHOOL ACTIVITIES PROGRAM

TUITION CONTRACT

My child _____ will attend OASAP, on the following days

Monday Tuesday Wednesday Thursday Friday

- Tuition \$21 per day first child, \$18 per day for each additional child. Early dismissal day tuition is \$27 for the first child, \$25 second child, \$23 third child.

I would like to be billed (please circle)

MONTHLY

2 INSTALLMENTS (Sept. & Jan.)

YEARLY

- No child may attend the program until all completed paperwork as well as any doctor's orders & medication has been given to the OASAP office.
- Tuition payments are due on the first day of the month that your child attends.
- If you are having financial difficulties please speak with the Program Director to make a payment plan. If tuition assistance is needed the Program Director will provide a list of agencies who may offer financial assistance. Any information will be strictly confidential.
- If account is not paid in full by the end of the month and the Program Director has not been contacted, your child/children will not be allowed to attend beginning the first day of the next month. If tuition is not paid by the end of the next week your families slot at OASAP will be terminated.
- Tuition is based on the number of days your child/children are scheduled to attend, regardless of any absences. If school is closed due to snow day, inclement weather or any other reason the school deems necessary, accounts will be billed if it is your regularly scheduled day.
- Days may not be switched during the week, but one may be added if there is availability.
- OASAP closes at 5:30 p.m., a late charge of \$15 will be charged to all parents arriving after 5:30 to pick up their child/children. This \$15 is charged for any portion of the first fifteen minutes, after which the charge is \$1.00 per minute. This charge will be added to your account and must be paid by the end of the week. If we do not hear from you and your child remains at the program past 6:15, the Orleans Police Department may be notified. Chronic lateness will result in your child's dismissal from the program.
- For other questions regarding OASAP policies please refer to the parent handbook or speak with the director.

I have read and understand the parent handbook as well as this tuition contract and agree to adhere to the policies therein.

Parent/Guardian Signature

Date

For the 2019-2020 school year OASAP will be using email billing, as well as a new system to reach parents for reminders and group information. We are asking parents to fill out this form so that we have all email addresses that you would like your bill to go to as well as all cell phone numbers you would like reminders to go to.

Child's Name _____

Parent/ Guardian name _____

Email address _____

Cell phone number _____

Parent/ Guardian name _____

Email address _____

Cell phone number _____

Email bill _____

Print bill _____