Start Date:______________

Days Attending:____________

Hours Attending: __________

Susanna Wesley School-Age Programs

7433 SW 29th St.
Topeka, KS 66614
785-478-3703
gabby@swumc.org

Enrollment Application for Summer Camp 2019

~ Personal Information ~

Camper's Name:________________________________ Gender: ________Date of Birth: ______________________

Address: ____ Phone: ___________________________
Street City Zip Code

Mother/ Guardian: ____________________________Home Phone: _____________ Cell Phone: ______________________

Home Address: ____
Street City Zip Code

Home E-Mail Address:____

Occupation: ____________________ Place of Employment: ___________________ Work Phone: _____________

Work Address: ____
Street City Zip Code

Work E-Mail Address: ____

Father/Guardian: ____________________________Home Phone: _____________Cell Phone: ______________

Home Address: ____
Street City Zip Code

Home E-Mail Address:____

Occupation: ____________________ Place of Employment: ___________________ Work Phone: ____________________

Work Address: ____
Street City Zip Code

Work E-Mail Address:____

~ E-Mail Address ~

Please list an e-mail address(s) that you would like us to use for correspondence:

____

~ Publicity Release ~

I grant permission for my camper to be involved in publicity for Susanna Wesley Summer Camp Program, which may include:
(Please check any or all of those you consent to):

For Use By SWUMC Only

______ Audio / Visual Recording
______ Photographs for Website, Social Media, Picture CD

For External Use

______ Television
______ Newspaper

~ Medical Conditions ~

Does your camper have any drug, food, or pet allergies or is there anything else we should be aware of?

____

____

~ Local Emergency Pick-Up List ~

Person(s) allowed to pick up your camper with parental consent, or to contact in case of inability to locate parent(s):

1. Name: ______________________________ Relationship: ______________________

   Address:____________________________City:______________ Zip:________________

   Home Phone: ____________ Work Phone: ______________ Cell Phone: __________________

2. Name: ______________________________ Relationship: ______________________

   Address:____________________________City:______________Zip:________________

   Home Phone: ____________ Work Phone: ______________ Cell Phone: __________________

~ Doctor and Hospital Information ~

Name of Doctor:____________________________

Address:____________________________ City:______________ Zip:________________

Phone Number:__________________________

Name of Hospital Preference in case of emergency:______________________________________

Health Insurance Policy Name:__________________________ Policy Number:________________

~ Sunscreen/Bug Spray ~

Parents are to provide Sunscreen or Bug Spray for their child, and please make sure your child's name is written somewhere on the bottle. For bug spray a short-term medication form must be on file before we can apply.

I certify that all information on this enrollment form is correct:

Parent Signature: ______________________________________ Date: ____________________

A non-refundable one-time activity fee of $150 must accompany this application.

How did you hear about us?

_____Capital-Journal ____Friend ____Phone Book (please indicate which)________________

_____Sherwood Gazette ____Mother & Child Magazine ____Sign Out Front of Church

_____SWUMC Website ____SWUMC Facebook Page

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Kansas Department of Health and Environment
Bureau of Family Health
Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: (785) 296-1270 Fax (785) 559-4244
Website: www.kdheks.gov/kidsnet

HEALTH HISTORY FOR CHILDREN AND YOUTH ATTENDING SCHOOL AGE PROGRAMS

As required by K.A.R. 28-4-590(d) (1), each operator shall obtain a health history for each child or youth, on a form supplied by the department or approved by the secretary. Each health history is to be maintained in the child's or youth's file on the premises. As required by K.A.R. 28-4-590(d)(2), each operator shall require that each child or youth attending the program has current immunizations as specified in K.A.R. 28-1-20 or has an exemption for religious or medical reasons.

Complete one form for each child or youth attending the School Age Program.

First and Last Name of the Child or Youth	Gender (M or F)	Date of Birth (MM/DD/YYYY)	First day at this program: (MM/DD/YYYY)

First and Last Name of the Child's or Youth's Mother or Guardian

Mother/Guardian's Home Street Address	City	Zip Code	Home Phone # ( )

Mother/Guardian's Work Place Name & Street Address	City	Zip Code	Work Phone # ( )

First and Last Name of the Child's or Youth's Father or Guardian

Father/Guardian's Home Street Address	City	Zip Code	Home Phone # ( )

Father/Guardian's Work Place Name & Street Address	City	Zip Code	Work Phone # ( )

Names and ages of other children in the Child or Youth's Family (Attach additional page if needed.)

Person(s) authorized to pick up the Child or Youth in case of emergency. Include first and last name and Street Address. Attach additional page if needed.	City	Zip Code	Phone Number (during program hours):
1.			
2.			
3.			

First and Last Name of Physician & Street Address	City	Zip Code	Phone Number ( )

Name of Hospital Preference in case of emergency.

Yes	No	N/A	Complete the following information about medications for this child or youth.
			Will this child or youth need to take any nonprescription or prescription medication during their time at the program?
			If yes above, is there signed permission on file?

Circle any of the following conditions or difficulties that affect this child or youth.			
Allergies	Frequent sore throats/ colds	Ear Infections or Aches	Heart or Lung Conditions
Skin Problems	Asthma	Headaches	Diabetes
Vision	Speech/Communication	Hearing	Emotion/Behavior
Other: Please describe.			

If you circled any of the above conditions, please provide additional information that will help the staff members meet the child's or youth's needs while attending the program. (Attach additional page, if needed.)

Provide additional information about your child or youth that might affect him/her while at the School Age Program including any special needs, restrictions to activities, major changes at home or special instructions. (Attach additional page, if needed.

Complete the following information about this child's or youth's immunization status.

Yes	No	
		Did this child or youth attend a public or accredited non-public school in Kansas, Missouri or Oklahoma the previous year?
		If yes, are this child's or youth's immunizations current?
X	X	If yes to both of these questions, you do NOT need to complete the immunization history below. If no to either of the above questions, you must complete the immunization history below for this child or youth or attach a copy of the child's or youth's immunization history.

Please give dates in the space below for ALL immunization series completed by this child or youth. Record MM/DD/YYYY.

		1	2	3	4	5
	DPT, DT*, TD (*DT only if child is allergic to DTP)	/ /	/ /	/ /	/ /	/ /
	POLIO	/ /	/ /	/ /	/ /	
	MMR	/ /	/ /			
Single Dose Only	RUBEOLA (MEASLES)	/ /	/ /			
	MUMPS	/ /	/ /			
	RUBELLA (GERMAN MEASLES)	/ /	/ /			
	HIB (Hemophilus Influ. B) *RECOMMENDED	/ /	/ /	/ /	/ /	
	HBV (Hepatitis B Vaccine) *RECOMMENDED	/ /	/ /	/ /		
	VAR (Varicella-Chicken Pox) *RECOMMENDED	/ /				

Print the First and Last Name of the Person Completing this Health History form	Relationship to the Child/Youth	Date Completed

If the Health History form was completed by a person other than a Parent/Guardian, who provided you with this information?	What is that person's relationship to the child/youth?

I attest, under penalty of perjury, that to the best of my knowledge, the information provided on this form is true and correct.

Signature of person completing this form	Date Signed

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Kansas Department of Health and Environment
Bureau of Family Health
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Child Care Program: (785) 296 -1270 Fax: (785) 559-4244
Website: www.kdheks.gov/kidsnet

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

Written permission for emergency medical treatment must be on file at the facility. Consult with the local emergency medical facility to be sure this form is acceptable. Reference K.A.R. 28-4-127(b)(1)(A). School Age Programs reference K.A.R. 28-4-582(e)(2).

Name of facility exactly as stated on the license.	**License #**
Susanna Wesley School Age South	0057315-009

I hereby authorize Gabriella Harris ______ (Name of individual/staff member) and/or

SWCC Staff ______ (Name of individual/staff member) who is (are) representative(s) of the

above named facility to give consent for any and all necessary emergency medical care for my child or youth ______

______ (First and Last Name of Child or Youth) while said child or youth is in said facility's

custody between the dates of 05/28/2019 ______ and 08/09/2019 ______.
MM/DD/YYYY MM/DD/YYYY

Signature of Parent or Guardian	**Date Signed**

Witness to Parent's or Guardian's signature if required by the local hospital or clinic.	**Date Signed**

Notarization of Parent's or Guardian's signature if required by local hospital or clinic.

State of Kansas
County of ______

Signed or attested before me on ______ by ______.
MM/DD/YYYY Name of Person

(Seal, if any.)

______
Signature of notarial officer

______
Title (and Rank)
My appointment expires: ______

List any known allergies or other information about the medical status of this child or youth pertinent in case of emergency:

______

______

Is child covered by health insurance? ☐ **Yes** ☐ **No**

If yes, complete the following:

Health Insurance Policy Name ______ Policy Number ______
Medical Assistance Program ______ Card Number ______
Military Medical Care I.D. Number ______

If known, date of last Tetanus inoculation: ______

THE MEDICAL RECORD/ASSESSMENT FORM (OR HEALTH STATUS HISTORY FORM FOR SCHOOL AGE PROGRAMS) AND THE AUTHORIZATION FOR EMERGENCY MEDICAL CARE MUST BE TAKEN TO THE EMERGENCY ROOM. BOTH FORMS MUST ALSO BE IN A VEHICLE WHEN THE CHILD OR YOUTH IS TRANSPORTED BY THE FACILITY.

Susanna Wesley School-Age Programs

Summer Camp 2019 Contract for Fees

I,____, contract for services of the Susanna Wesley Summer Camp Program
(parent) for my Camper as specified below:

Address: ____ Grade in fall 2019: ____________________

City: ____ State: ______________________ Zip: ________________________

Daytime Phone: ____ Home Phone: _______________________________

Camper Name: ______________________________Grade (fall 2019):______________Rate $ ______T-Shirt Size: ___________

Camper Name: ______________________________ Grade (fall 2019):______________ Rate $________ T-Shirt Size: __________

Camper Name: ______________________________ Grade (fall 2019): _____________ Rate $ ________T-Shirt Size: __________

My camper(s) will attend on the following days: M T W Th F

During the hours of: AM Arrival: ____________________ PM Departure: __________________________

(Summer Camp hours are 7 am to 6 pm)

Activity fee is $150 per child and covers all field trips. This is non-refundable.
****Full Time Fee is $1540 for eleven weeks which can be paid in weekly installments of $140/week. No early withdrawals allowed.****

Please read carefully:

Additional Fee Information:

Late Departure Fees: It is the Summer Camps policy to charge an additional fee for late pick up. Charges are $3 per minute with no grace period. This fee is payable the night of the occurrence or the following morning. If fee is not paid the camper will not be allowed to return until it is paid.

Return Check Fee: The center's policy is to charge a fee of $40.00 for returned checks. After two returned checks, cash or money order will be required for payment.

Late Payment: Checks are due each Friday for the upcoming week of care. At 6:00pm on Monday, payments that have not been received are subject to a $5.00 late fee, and care will be suspended until account is paid in full. Failure to pay fees may result in immediate termination of summer camp services.

By signing this contract,

- I acknowledge that I have read the Susanna Wesley Summer Camp Handbook posted on the Susanna Wesley United Methodist Church's website (www.swumc.org) and agree to be bound by its policies.
- I have read this contract and agree to pay the above stated tuition and any other fees that I may incur.
- I agree to complete the Enrollment Form and Contract and return them to the office no later than 1st day of care with the understanding that until these two forms along with activity fee payment of $150.00 are turned in my child is not enrolled in summer camp. Remember children are enrolled on a first come first served basis.
- I understand that I am to keep Susanna Wesley updated on any changes to my Enrollment Application and/or my Contract.

I also understand that any change in enrollment must be approved by the Administrator and must be accompanied by a new Enrollment/Contract for Fees form. Any change in enrollment requires a **two-week written notice** regardless of camper's attendance. **Remaining tuition payment for the summer will need to be given at time of notice.** Susanna Wesley reserves the right to terminate this contract at any time and for any reason. No changes to the fee schedule will be approved prior to the completion of this form.

I understand that once I sign and return this agreement I am obligated to pay **the entire amount of $1540**. Weekly installments are available. No reimbursements/credits for sick, unused time and/or vacation will be given. If camper is withdrawn before the end of the camp (08/10/19) any remaining balances must be paid in full at time of withdrawal. I indemnify and hold SWCC and its employees harmless from any liability or medical payments resulting from my child's participation in this summer camp.

THE SUMMER CAMP RESERVES THE RIGHT TO INCREASE FEES UPON 30-DAY NOTICE.

Mother's signature ____Date ___________________

Father's signature ____Date ___________________