



**Susanna Wesley School-Age Programs**  
**7433 SW 29<sup>th</sup> St. Topeka, KS 66614**  
**785-478-3703**  
[elisha@swumc.org](mailto:elisha@swumc.org)

Start Date: _____
Days Attending: _____
Hours Attending: _____

**Enrollment Application for Summer Camp 2021**

**Personal Information**

Child Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
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 child to be involved in publicity for Susanna Wesley School-Age Program, which may include:

(Please check any or all of those you consent to):

For Center Use Only

\_\_\_\_\_ Audio / Visual Recording  
 \_\_\_\_\_ Photographs for Picture CD

Other

\_\_\_\_\_ Television  
 \_\_\_\_\_ Newspaper

\_\_\_\_\_ Social Media  
 \_\_\_\_\_ Website

## Medical Conditions

Does your child have any drug, food, or pet allergies or is there any other medical conditions we should be aware of? If yes, please explain:

## Local Emergency Pick-Up List

Person(s) allowed to pick up your child 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: \_\_\_\_\_ Hospital of 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 \$200 must accompany this application.**

How did you hear about us?

\_\_\_\_ Capital Journal      \_\_\_\_ Friend      \_\_\_\_ Phone Book/which one \_\_\_\_\_

\_\_\_\_ Sherwood Gazette      \_\_\_\_ Mother & Child Magazine      \_\_\_\_ Sign Out Front



**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. 28-4582(e)(2).**

<b>Name of facility exactly as stated on the license.</b>	<b>License #</b>
Susanna Wesley School Age South	0057315-013

I authorize Elisha Haverkamp / Susanna Wesley Child Care (caregiver/staff) 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  (child's first and last name) while child or youth is in the facility's custody between  and .

MM/DD/YYYY MM/DD/YYYY

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:

MM/DD/YYYY

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

<b>Signature of Parent or Guardian</b>	<b>Date Signed</b>
<b>Witness to Parent's or Guardian's signature if required by the local hospital or clinic.</b>	<b>Date Signed</b>

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:



**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.**

<b>First and Last Name of the Child or Youth</b>	<b>Gender (M or F)</b>	<b>Date of Birth (MM/DD/YYYY)</b>	<b>First day at this program: (MM/DD/YYYY)</b>
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<b>First and Last Name of the Child's or Youth's Mother or Guardian</b>
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<b>Mother/Guardian's Home Street Address City</b>	<b>City</b>	<b>Zip Code</b>	<b>Home Phone # ( )</b>
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<b>Mother/Guardian's Work Place Name &amp; Street Address City</b>	<b>City</b>	<b>Zip Code</b>	<b>Work Phone # ( )</b>
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<b>First and Last Name of the Child's or Youth's Father or Guardian</b>
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<b>Father/Guardian's Home Street Address</b>	<b>City</b>	<b>Zip Code</b>	<b>Home Phone # ( )</b>
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<b>Father/Guardian's Work Place Name &amp; Street Address</b>	<b>City</b>	<b>Zip Code</b>	<b>Work Phone # ( )</b>
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<b>Names and ages of other children in the Child or Youth's Family (Attach additional page if needed.)</b>
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<b>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.</b>	<b>City</b>	<b>Zip Code</b>	<b>Phone Number (during program hours):</b>
1.			
2.			
3.			

<b>First and Last Name of Physician &amp; Street Address</b>	<b>City</b>	<b>Zip Code</b>	<b>Phone Number ( )</b>
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<b>Name of Hospital Preference in case of emergency.</b>
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Yes	No	N/A	<b>Complete the following information about medications for this child or youth.</b>
			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?

<b>Select any of the following conditions or difficulties that affect this child or youth.</b>			
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 selected 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
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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?
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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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# Susanna Wesley School-Age Program

## Summer Camp Fees Contract

### Effective for Summer 2021

I, \_\_\_\_\_, contract for services of the SW Kids Summer Camp Program for my  
(Parent Name)  
 camper as specified below:

Address: \_\_\_\_\_ Grade in fall 2021: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Camper Name: \_\_\_\_\_ Grade (fall 2021): \_\_\_\_\_ Rate \$ \_\_\_\_\_ T-Shirt Size: \_\_\_\_\_

Camper Name: \_\_\_\_\_ Grade (fall 2021): \_\_\_\_\_ Rate \$ \_\_\_\_\_ T-Shirt Size: \_\_\_\_\_

Camper Name: \_\_\_\_\_ Grade (fall 2021): \_\_\_\_\_ 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: \_\_\_\_\_

**Activity fee is \$200 per child and covers all field trips. This is non-refundable.**  
**\*\*Full Time Fee is \$1,550 for ten weeks which can be paid in**  
**weekly installments of \$155/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 \$15 first ten minutes then a \$1 every minute after that 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 \$30.00 for returned checks. After two returned checks, cash or money order will be required for payment.

**Late Payment:** Checks are due each THURSDAY for the upcoming week of care. On Friday, payment is considered late and a \$10 late fee will be assessed. Your child will not be able to attend the following week until paid. If you receive four late fees within a program contract, your child may be subject for dismissal.

**By signing this contract,**

- ❖ I acknowledge that I have read the SW Kids Summer Camp Handbook posted on the Susanna Wesley United Methodist Church's website ( [www.swumc.org](http://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 first day of care with the understanding that until these two forms along with activity fee payment of \$200 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 director and must be accompanied by new enrollment forms and 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 \$1,550.** Weekly installments are available. No reimbursements/credits for sick or unused time will be given regardless of the circumstance. If camper is withdrawn before the end of the camp (08/09/21) any remaining balances must be paid in full at time of withdrawal. I indemnify and save 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** \_\_\_\_\_