

Winchester Recreation After-School Program
263 Main St
Winchester, MA 01890
781-721-7125
Enrollment Form
2024-2025

Child's Name: _____ Eye Color: _____ Skin Color: _____
Home Address: _____ Hair Color: _____ Height: _____
Telephone: _____ Sex: _____ Weight: _____
Date of Paperwork: _____ Age at Start of School Year: _____
Date of Birth: _____ Primary Language: _____
Identifying Marks: _____
School: _____ Grade: _____
Allergies*/special diet: _____

If your child has allergies an additional health care form must be filled out and signed by your health care provider

PARENT/GUARDIAN INFORMATION:

Parent/Guardian Name: _____
Home Address: _____
Home Telephone: _____
Cell Phone: _____
Email: _____
Work Name: _____
Work Address: _____
Work Phone: _____

Parent/Guardian Name: _____
Home Address: _____
Home Telephone: _____
Cell Phone: _____
Email: _____
Work Name: _____
Work Address: _____
Work Phone: _____

Individual Health Care Plan Form 2024-2025

(ONLY NEEDS TO BE FILLED OUT IF YOUR CHILD HAS A HEALTH CARE PLAN)

Child's Name: _____

Plan must be renewed annually or when child's condition changes.

Plan was created by: Place an X on all that apply.

- Parent
 Director
 Doctor or Licensed Practitioner
 Program's Health Care
 Consultant Older school age child (9+ years of age)

Plan is maintained by: Check all that apply.

- Child's Educator
 Other: _____

Description of chronic health care condition: _____

Symptoms: _____

Medical treatment necessary while at the program: _____

Potential side effects of treatment: _____

Potential consequences if treatment is not administered: _____

Name of educators that received training addressing the medical condition: _____

Person who trained the educator (child's health care practitioner, child's parent, program's Health Care

Consultant) Name of Licensed health Care Practitioner (print name) _____ Date _____

Licensed Health Care Practitioner consent: _____ Date _____

Parental/Guardian Consent: _____ Date _____

For Children 9+ years of age

With written parental consent and authorization of a licensed health care practitioner, this individual Health Plan permits older school age children to carry their own inhaler and /or epinephrine auto-injector and use them as needed without the direct supervision of an educator.

The educator is aware of the contents and requirements of the child's Individual Health Plan specifying how the inhaler or epinephrine auto-injector will be kept secure from access by the other children in the program. Whenever an Individual Health Care Plan provides for a child to carry his or her own medication. The licensee must maintain a back-up supply of the medication for use as needed.

Age of child: _____ Date of birth: _____ Back-up medication received? Yes No

Parent Signature: _____ Date: _____

Administrator's signature: _____ Date _____

FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM

Child's Name: _____ Date of Birth: _____

Child's Physician Name: _____

Address: _____

Phone Number: _____

Child's Allergies: _____

Chronic Health Conditions: Medical, dietary, ADHD, auditory, etc.)

Emergency Contacts (In order to be contacted)

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

Name _____

Address _____

Relationship to child _____

Home Phone _____ Cell Phone _____

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

Name _____

Address _____

Relationship to child _____

Home Phone _____ Cell Phone _____

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

Name _____

Address _____

Relationship to child _____

Home Phone _____ Cell Phone _____

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

Health Insurance Provider: _____ Policy # _____

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 requirements are on file at my child's school. Please initial _____

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 care facility and to secure necessary medical treatment for my child.

Parent/Guardian Signature

Date (valid for one year)

Authorizations/Permissions

Child's Name: _____

SUNSCREEN/INSECT REPELLENT PERMISSION: We expect that all children will arrive daily with sunscreen/insect repellent already applied. If your child needs to reapply, they may do so independently. If your child will need assistance from a staff member, we must receive prior authorization to do so. You must send your child in with sunscreen/insect repellent labeled with their name on it.

I hereby authorize the Winchester Recreation Staff to apply sunscreen on my child as needed.

I **do not** authorize the Winchester Recreation Staff to apply sunscreen on my child.

I hereby authorize the Winchester Recreation Staff to apply insect repellent on my child as needed.

I **do not** authorize the Winchester Recreation Staff to apply insect repellent on my child.

SLEDDING PERMISSION

I give permission for my child to go sledding during the winter months while he/she attends the Winchester Recreation After-School Program.

I **do not** authorize my child to go sledding during the winter months while he/she attends the Winchester Recreation After-School Program.

OFF SITE ACTIVITIES

I give permission for my child to participate in all of the regularly scheduled on-going activities located at local walkable locations, in the proximity of the after school program.

MEDIA RELEASE INFORMATION

Student photographs may be used in newsletters or publications, Rec. Facebook Page and Winchester Recreation brochures.

Please check:

I hereby consent to and authorize The Winchester Recreation afterschool program to use photographs produced of my child for publicity purposes.

I **do not** consent and authorize my child being included in any photographs of my child.

TOOTH BRUSHING AUTHORIZATION/WAIVER

I **do not** wish for my child to participate in toothbrushing while here at W.R.A.P.

I wish to have my child participate in tooth brushing. I am responsible for providing my child's toothbrush and toothpaste labeled with their name on it and will be replaced every 3 months.

ALCOHOL-BASED HAND SANITIZER: If soap and water are not available, alcohol-based hand sanitizers (with at least 60% alcohol) are an effective alternative for cleaning hands and are recommended as an alternative to soap and water by the Centers for Disease Control and Prevention (CDC) and Massachusetts Department of Public Health (MDPH).

I give permission for my child to use hand sanitizer after-school.

I **do not** give permission for my child to use hand sanitizer in after-school

Parent/Guardian Signature _____ Date _____

School year Transportation Plan and Authorization

Childs Name: _____ Date of Birth: _____

My Child is registered for the following days:

Monday	Tuesday	Wednesday	Thursday	Friday
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

My Child will arrive at the program by:

	Parent/Authorized Drop off	Unsupervised walk	Supervised walk (indicate by whom)	School Bus Drop Off
After school	<input type="checkbox"/>			<input type="checkbox"/>

My Child will depart the program by:

	Parent/Authorized pick up	Unsupervised walk*	Supervised walk (indicate by whom)
After School	<input type="checkbox"/>	<input type="checkbox"/>	

*** Complete "Consent for Child to Leave the School Age Child Care Program" form per CMR 7.04(7)(a)8**

I give permission for my child to be released from the program at the end of the day as stated above and/or I give my permission to release my child to the following people.

Name _____
 Address _____
 Relationship to child _____
 Home Phone _____ Cell Phone _____

Name _____
 Address _____
 Relationship to child _____
 Home Phone _____ Cell Phone _____

Name _____
 Address _____
 Relationship to child _____
 Home Phone _____ Cell Phone _____

THIS PERMISSION IS VALID FOR ONE PROGRAM YEAR FROM THE DATE OF SIGNATURE. ANY OTHER TRANSPORTATION REQUESTS MUST BE STATED IN WRITING.

Parent/Guardian Signature: _____ Date: _____

CONSENT FOR CHILDREN 9 YEARS AND OLDER FOR LEAVING THE PROGRAM

Child MUST be 9 years old or older

This form is to be used if the child has permission to walk home at the end of the program day or any time a child has permission to leave the program to attend enrichment programs separate from the childcare program.

Program Name: _____

Address: _____

I, _____ authorize my child, _____

(Parent/Guardian's Name)

(Child's name)

to leave the program. This permission is in effect from _____ to _____

Date

Date

Activity/Location: _____

Method of Transportation: _____

Leave Time: _____ Return Time: _____

Restrictions: _____

Activity/Location: _____

Method of Transportation: _____

Leave Time: _____ Return Time: _____

Restrictions: _____

Activity/Location: _____

Method of Transportation: _____

Leave Time: _____ Return Time: _____

Restrictions: _____

Activity/Location: _____

Method of Transportation: _____

Leave Time: _____ Return Time: _____

Restrictions: _____

Activity/Location: _____

Method of Transportation: _____

Leave Time: _____ Return Time: _____

Restrictions: _____

I understand that the program has the right to rescind the above privilege if my child's behavior warrants the limitation.

I recognize that my child will not be supervised by staff while s/he is away from the program.

I understand I am responsible for my child once s/he leaves the program.

(Parent/Guardian Signature)

(Date)

(Program Staff Signature)

(Date)

**Payment Authorization
Form 2024-2025**

Child's Name: _____

Parent's Name: _____

Program: _____

I understand that the above program is to be paid on an automatic monthly payment.

The W.R.A.P. program's first payment will be taken out on June 15th for September enrollment.
Any changes in care or withdrawals must be done 30 days in advance.

Our recreation registration system will automatically bill your credit card on the 1st of each month's program fees, starting in September and ending in May. You must contact the Recreation Department if your credit card changes during the course of the school year in order to update the billing information in our system.

MasterCard

Visa

Discover

Credit Card Number: _____

Please call the office with your credit card #, mail or drop off this form in person. Do not email.

Expiration Date: _____

3 Digit Security Code (on back of card): _____

Signature: _____

Date: _____

Billing Address: _____

Child Care Policy Receipt Form

I have received, read and understand the policies of The Winchester Recreation Department Childcare Programs as stated in the parent handbook.

Parent/Guardian Signature

Date

Parent/Guardian Printed Name

Child/ren name/s:

