Ballston Area Community Center

20 Malta Ave.
Ballston Spa, NY 12020
(518) 885-3261
www.ballstonareacc.org

2020 Summer Program Application

Please be sure to complete all the information requested in this application. Incomplete applications will be returned to the parent/guardian. **ALSO NOTE**: By completing the following information and submitting for enrollment, the responsible parent/guardian verifies that they are in understanding of all policies, regulations and payment expectations pertaining to the BACC 2020 Summer Program.

CHILD'S INFORMATION					
Child's Last Name: First: Middle:		□ Male □ Female	Grade Entering Sept. 2019:	Home Phone: ( )	
Street Address:	City:	State:	Zip Code:	Birth Date: / /	Age:
PARENT/GUARDIAN #1					
Parent/Guardian Last Name: First: Middle:		Employer:		Work Phone: ( )	
Street Address:	City:	State:	Zip Code:	Home Phone: ( )	
Email Address:				Cell Phone: ( )	
PARENT/GUARDIAN #2					
Parent/Guardian Last Name: First: Middle:		Employer:		Work Phone: ( )	
Street Address:	City:	State:	Zip Code:	Home Phone: ( )	
Email Address:				Cell Phone: ( )	

Program Enrollment (Check one):

- ❑ Summer Program
- ❑ Summer Travel Program **(Gordon Creek)**
- ❑ **Shirt Size(Circle): YS YM YL AS AM AL AXL**

All programs require a $10.00 registration fee per family.

Travel Program is for children ages 10-15 years old.

ENROLLMENT DATES						
WEEK	**DATE**	**SUMMER PROGRAM WEEKLY FEES**	**TRAVEL PROGRAM WEEKLY FEES**	**DEPOSIT $50/per week**	**BALANCE DUE or PAID IN FULL**	**BALANCE DUE PAY DATE**
1	**7/6/2020**	**$190**	**$225**			**7/8/20**
2	**7/13/2020**	**$190**	**$225**			**7/15/20**
3	**7/20/2020**	**$190**	**$225**			**7/22/20**
4	**7/27/2020**	**$190**	**$225**			**7/29/20**
5	**8/3/2020**	**$190**	**$225**			**8/5/20**
6	**8/10/2020**	**$190**	**$225**			**8/12/20**
7	**8/17/2020**	**$190**	**$225**			**8/19/20**
8	**8/24/2020**	**$190**	**$225**			**8/26/20**

Program Hours: M-F, 6:30am-5:30pm. (Travel 6:45-5:30pm) _____: Parent initial
Expected arrival time for this child: _____am
Expected departure time for this child: _____pm

EMERGENCY CONTACT INFORMATION/ PARENT AUTHORIZATION FOR PICK UP

Please complete the following information for people to contact in the event of an emergency if parents cannot be reached and who is authorized to pick up your child. Add additional sheets or comments if necessary:

Name:_____
Relationship to child:_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____

Name:_____
Relationship to Child:_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____

Name:_____
Relationship to Child:_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____

Name:_____
Relationship to Child:_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____

BACC Summer Program Payment Agreement

I understand that at the time of registration, my child/ren DSS members must provide a CURRENT Acceptance Letter by JUNE 1.

I understand that the cost listed above represents the full cost of each week my child is enrolled in the program. I understand that the person signing this agreement is responsible for payment for each week my child/ren attends the program.

I understand I will be charged a processing fee if any payments are returned for insufficient funds.

I understand that it is the policy of the BACC to charge a late fee if I am late picking my child up. The late pick up fees are $5 per child for the first 15 minutes and $1 per minute thereafter, payable to the BACC at the time the child/ren is(are) signed out.

The Ballston Area Community Center reserves the right to refuse childcare services if my child is picked up late more than (3) times during the season. I also understand that the Ballston Area Community Center may be required to report my child/ren as abandoned to the New York Office of Children and Family Services if my child/ren has not been picked up from the program by 7pm.

SIGNATURES: The above terms have been read, are understood and agreed to, and I am enrolling my child in the Ballston Area Community Center Summer Travel Program.

Parent/Guardian Signature: _____

HEALTH HISTORY

New York State requires each child to have an immunization record on file with the Program office prior to attending the program. Your child will not be permitted to attend program without the proper records on file. Please complete the following information, as well as have the child's Health Care Provider complete the Physical / Immunization Form following this page.

Name of Pediatrician:_____Phone Number:_____
Address:_____

Name of Dentist:_____Phone Number:_____
Address:_____

Known Allergies:_____

Does your child have any special conditions (medical, behavioral or otherwise) that the staff should be aware of? Please be specific. **A Special Health Care need is defined as "a child who has a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and who requires health and related services of a type or amount beyond that required by children general."**

_____
_____
_____

MEDICATION WILL NOT BE D1SPENSED FOR ANY REASON IF THIS PORTION IS NOT FILLED OUT BY A PARENT OR GUARDIAN.		
I hereby give the, Program Medical Designee, or the Activities Director permission to dispense the following medication(s) to my child in the following manner:		
Medication:	Dosage:	Times:
Parent/Guardian Signature:	Date:	
Medication:	Dosage:	Times:
Parent/Guardian Signature:	Date:	
Medication:	Dosage:	Times:
Parent/Guardian Signature:	Date:	
All medications must be given to us in the original pharmacy bottle and we must have enough for the entire week. Please note that all medication must be given to the Program Medical Designee or the Activities Director only.		

Are there any activities in which this child should not participate?:

_____
_____
_____

AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

Childs Name:_______________________________________ DOB:__________________

I,_____________________________________, being the parent and/or legal guardian of the above mentioned child, grant permission to the Ballston Area Community and its authorized representatives to furnish or arrange for the furnishing of such hospital and/ or medical care as the above mentioned child may require during such time as he/she is at the Ballston Area Community Center's day program.

This medical care shall include, but not be limited to, examinations, treatments, immunizations, injections, anesthesia, surgery, and other procedures, etc.

This permission is conditioned upon the understanding that in the event of serious illness or accident, or in the event of a need for hospital services and/or major surgery, said person will use all reasonable efforts to contact the undersigned. Failure in such efforts, however, shall not prevent the provision of emergency treatment necessary for the best interest of the life and health of the said child.

For and in consideration of said covenants, the child and the undersigned hereby release, acquit, and covenant to hold harmless the said Program Health Director and all other persons, firms, officers, and corporations from all claims, damages, and causes of action of whatever nature which may accrue to the said child or the undersigned, their heirs, executors, administrators and legal representatives and assigns, arising out of any of the above procedures.

____

Signature of Parent/Guardian Print Name Date

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INSURANCE INFORMATION

Insurance coverage for accidents or illnesses while at the Ballston Area Community Center Program is the responsibility of the child and/or family. Please list your family health, accident, medical or hospital insurance coverage:

Insurance Carrier/Government Program:____

Policy or Group No.:________________________________ Contact Phone:_________________________

Name of Responsible Party:____

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PHOTOGRAPHIC RELEASE

- ❑ I hereby grant permission for ____________________________ (child's name) to be photographed, with such pictures and names to be used in public relations and fund-raising efforts to promote programs of the Ballston Area Community Center.
- ❑ I do NOT grant permission for ____________________________ (child's name) to be photographed, with such pictures and names to be used in public relations and fund-raising efforts to promote programs of the Ballston Area Community Center.

____

Signature of Parent/Guardian Print Name Date

PG-13 MOVIES (Summer Travel Program Only)

I understand that on rainy days or due to other inconveniences, the children may be attending the movies and will be allowed to see a movie rated PG-13 along with other movie choices. Most movie days will provide different movies for the children to choose from.

□ **I give permission for my child to view movies rated PG-13 and below**

PERMISSION TO USE SUNSCREEN CREAMS & LOTIONS

Regulations state that parents/guardians must provide written instructions to the staff for the use of topical ointments, creams and lotions to be applied as needed for protection against the sun. Please complete the following as needed for your child.

I give my permission to the Ballston Area Community Center Day Program staff to apply the following per my instructions to the child stated in application:

Name of cream or lotion:____
Instructions:____

Please attach additional sheets if necessary

Signature of Parent / Guardian:____________________________ Date:__________

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SWIMMING LESSONS

To Be Completed for Regular Summer Program Only

Swimming Lessons are scheduled at the Ballston Spa Community Pool. All children are required to take lessons unless parents provide the Program Director with a written excuse. The program will also return to the pool in the afternoon for free recreational swim every day.

Safety is our first priority. Therefore a child that does not participate in swimming lessons will not be allowed in the afternoon recreational swim program.

My child______________________________(name of child) has my permission to participate in swimming lessons and recreational free swim at the Ballston Spa Community Pool, with the staff from the Ballston Area Community Center.

Although the lifeguards will test your child in the beginning of the summer, please check what swimming level you believe your child to be:

- ❑ Level 2 beginner
- ❑ Level 3 (2nd year beginner)
- ❑ Level 4 (Advanced beginner)
- ❑ Level 5 (Intermediate)
- ❑ Level 6

***Please note: There will be a separate fee for swimming lessons not included in the regular tuition fee.**

CONDITIONS OF ACCEPTANCE

- My son / daughter has permission to participate fully in the BACC Day Program, including being transported to and from field trip sites by the contracted Transportation Company.

- I understand that in the case of an emergency and I am unable to be reached, I authorize the BACC Day Program staff present to take action deemed necessary in my child's best interests.

- I understand the **$50.00 registration fee is a deposit for each week** my child wishes to attend the BACC Day Program, and is non-refundable. This deposit will be applied to the weekly fees.

- I agree that the balance in fees due for each week of Program my child is attending will be paid in full by the Wednesday prior to the start of each week. I also understand that my child will not be permitted to attend Program if these fees are not paid in full.

- I understand that there is NO REFUND of any fees for any voluntary withdrawal or dismissal. Withdrawal due to serious illness requires a Doctor's verification. **Program fees will be prorated, and payment for days unused will be refunded except for the $50.00/week registration fee and the $10.00 Family Registration Fee.**

- I release the Ballston Area Community Center, as well as the Office of Children and Family Services, and all its employees and volunteers, its officers, their parent affiliates, employees, volunteers, agents, underlying carriers, subcontractors, granting agencies, from any and all claims of responsibility for any injury that my child may incur from their participation.

- I understand that the Ballston Area Community Center does not carry Health and Accident Insurance for individual children and I am responsible for all health incurred costs.

Parent / Guardian Signature	Date
Witness Signature	Date

Ballston Area Community Center

20 Malta Ave.
Ballston Spa, NY 12020

Physical / Immunization Record

Child's Name:_____ D.O.B._____

Height:_____ Weight:_____

Immunizations: Include all dates

DPT:_____,_____,_____,_____,_____

Oral Polio:_____,_____,_____,_____

HIB:_____,_____,_____,_____

HEPATITIS B:_____,_____,_____

MMR:_____,_____,_____

FOR OFFICE USE ONLY
Date of Review:_____

Health Director:_____

Flags:_____

Health Specifics

- Allergies:_____
- Has child had any recent hospitalizations or illnesses? _____Yes _____No

If yes, please explain:_____

- Date of last Tetanus shot:_____
- Does this child have any special diet restrictions/requirements? _____Yes _____No

If yes, please explain:_____

- Does this child have any special mental / development conditions? ____Yes ____No

If yes, please explain:_____

- Does this child have any physical restrictions? ____Yes ____No

If yes, please explain:_____

- Does this child have any hearing, visual or dental limitations? ____Yes ____No

If yes, please explain:_____

On the basis of my findings, and on my knowledge of the above named individual, I find that he/she is free from contagious and communicable disease and is healthy: _____Yes _____No and he/she is able to participate in daily programming _____Yes _____No.

_____ _____

Signature of Examiner Date of Exam

Printed Name:_____ Phone:_____ Fax:_____

Address:_____