Ballston Area Community Center

20 Malta Ave.
Ballston Spa, NY 12020
www.ballstonareacc.org

2022-2023 School Age Care 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 2022-2023 School Age Care Program.

AM Program (6:30 am-9:00am) ☐ PM Program (3:00pm-6:00 pm) ☐

What site would you like your child to attend? (Check one) BACC? ☐ **Gordon Creek?** ☐

▪Name of Child: ______________________ Sex: ☐M F ☐

Grade (fall 2022):__________ Teacher (if available):__________

School attending (check): ☐ Milton Terr ☐Gordon Creek☐Malta Ave☐Wood Rd☐M.S.

Address: ______________________

City:______________________ State:__________ Zip:__________

Home Phone Number: ______________ Date of Birth: ____/____/____

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Name of Parent/Guardian: ______________________

Address:______________________ **Email** ______________

City:______________________ State:__________ Zip:__________

Place of employment:______________________

Work Address:______________________

Work Phone:______________ Home Phone:______________

Cell Phone: ______________ Work Hours ______ to ______ # of Days/Wk______

Name of Parent/Guardian (2):______________________

Address (if different than above):______________ **Email:**______________

City:______________________ State:__________ Zip:__________

Place of employment:______________________

Work Address:______________________

Work Phone:______________ Home Phone:______________

Cell Phone: ______________ Work Hours _____to _____ # of Days/Wk ________

My child currently resides in the following municipality (Please circle)

Milton	**Village of Ballston Spa**	**Malta**	**Rock City Falls**	**Town of Ballston**
☐	☐	☐	☐	☐

All Other Members of Household (including children not under BACC care):

Name	Age	Relationship
1. ______________	______	______________
2. ______________	______	______________
3. ______________	______	______________

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

____

____

Behavior Issues:

____

____

____

Anything else we should know to better serve your child and family?

____

____

Does your child have any special activities/ interest areas?

____

____

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INSURANCE INFORMATION

Insurance coverage for accidents or illnesses while at the Ballston Area Community Center School Age Care 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:______________________________

EMERGENCY CONTACT INFORMATION

Please complete the following information for people to contact in the event of an emergency and the parent/guardian(s) can not be reached:

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: _________________

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PARENT AUTHORIZATION FOR PICK UP

Please note that unless there is a legal document ON FILE with the BACC office stating that one parent is not allowed contact with a child, staff is NOT legally able to keep a non-custodial parent from picking up the child(ren). Please attach a copy of a legal document to this form if this situation applies to you.

I give permission for the following people (must be over 18 years of age) to pick up my child(ren) at the Ballston Area Community Center (BACC) School Age Care. I realize that my child(ren) will not be released to anyone who is not listed below unless BACC is informed with written permission.

I also understand that if a staff member does not recognize a parent or someone else on my child's pick up form, the staff person may ask for identification. It will be my responsibility to insure that each of the individuals listed below will have proper identification if required to present it to the BACC staff.

Additionally, all BACC staff reserves the right not to release a child to anyone that may be suspected of being under the influence of drugs or alcohol.

Authorized Persons: Parents/Guardians please include yourself. Attach additional sheets if necessary

Name:____ Relationship to Child:______________________
Home Phone:____________________ Work Phone:____________________ Cell Phone:________________

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Home Phone:____________________ Work Phone:____________________ Cell Phone:________________

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Home Phone:____________________ Work Phone:____________________ Cell Phone:________________

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Home Phone:____________________ Work Phone:____________________ Cell Phone:________________

Name:____ Relationship to Child:______________________
Home Phone:____________________ Work Phone:____________________ Cell Phone:_______________

FIELD TRIP RELEASE

☐ I hereby grant permission for ______________________________ (child's name) to attend any neighborhood field trips that the Ballston Area Community Center's School Age Care Program may have. I will be informed in advance of these outings. They include, but are not limited to, neighborhood walk, visit to the library, etc.

☐ I do NOT grant permission for ______________________________ (child's name) to attend any neighborhood field trips that the Ballston Area Community Center's School Age Care Program may have. They include, but are not limited to, neighborhood walk, visit to the library, etc.

____

Signature of Parent/Guardian Print Name Date

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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 fundraising 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 fundraising efforts to promote programs of the Ballston Area Community Center.

____

Signature of Parent/Guardian Print Name Date

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DISPENSING OF OVER-THE-COUNTER MEDICATION

I hereby grant permission for __________________________ (child's name) to receive any or all of these medications while at the BACC (Will only use as directed on the medication):

- ☐ Benadryl Spray (Itch Relief)
- ☐ Sunscreen
- ☐ OFF Bug Spray
- ☐ BAND AID Antiseptic Wash (Hurt Free).

FINANCIAL AGREEMENT

☐ I understand that I am responsible for securing my child's place in the BACC School Age Care Program with a $35.00 non-refundable/non-transferable deposit payment, due at time of registration.

☐ I agree to pay the Ballston Area Community Center the following amount at the **beginning** of each month _____ for the School Age Care Program fees. I understand that if my fees are more than two weeks delinquent, my child(ren) will be dismissed from the program.

☐ I understand that there will be a $20.00 late fee added to my child care account if BACC does not receive payment for services by the 5th of each month my child is enrolled in the program.

☐ I understand that I must give BACC a two-week advance notice if I choose to remove my child(ren) from the program. I also understand that any outstanding debts (fee payments, etc.) shall prohibit me and my child from enrolling or participating in any other programs offered by BACC until my balance is paid in full.

☐ I understand that I am responsible for and agree to pay a late fee of $1.00 per minute, per child for picking up my child(ren) after 6:00 p.m.

****PRE-REGISTRATION IS REQUIRED TWO WEEKS IN ADVANCE – FEES PAYABLE AT TIME OF REGISTRATION****

Child's Name:_____ Date:_____

Signature of Parent/Guardian:_____ Date:_____

SACC MONTHLY RATES

Before School

1 Child……. $205.00
2 Children……. $389.50
3 Children… …$574.00
4 Children…….$758.50

After School

1 Child……. $240.00
2 Children……$456.00
3 Children...…..$672.00
4 Children…..$888.00

****Adventure Days/ Snow Days****

1 Child……. $30.00
2 Children…....$57.00
3 Children…..$84.00

Half Days

1 Child……. $20.00
2 Children……. $38.00
3 Children…… $56.00

CONDITIONS OF ACCEPTANCE

- I agree the balance due for each month will be paid in full by the 5th day of each month that my child attends the program. **(Your child will not be permitted to attend the program if all fees are not paid in full.)**

- I understand that there is no refund of fees for any voluntary withdrawal or dismissal. Withdrawal due to serious illness requires doctor's verification, and unused program fees paid for and not attended due to serious illness will only be refunded with a valid medical excuse.

- I understand the **$35.00** registration deposit is non-refundable/non-transferable and is separate from monthly fees.

- 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 or accident 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.

- If an emergency occurs when no one can be reached, I authorize the adults present to take action deemed necessary in my child's best interest.

- I will notify the BACC School Age Care staff of changes in home/emergency telephone numbers.

- My child has my permission to participate in the School Age Care Program sponsored by the Ballston Area Community Center.

- I have received, reviewed, completed and/or signed the following:

☐ Family Handbook	☐ Emergency Contacts
☐ Registration Form	☐ Emergency Medical Authorization
☐ Conditions of Acceptance	☐ Parent Authorization for Pick Up
☐ Financial Agreement	☐ Physical / Immunization Form

_____ _____

Parent/Guardian Signature Date

HEALTH HISTORY

BACC requires each child to have an immunization record on file with the School Age Care office prior to attending the program. Your child will not be permitted to attend the program without the proper records on file. Please complete the following information, as well as have the child's health care provider complete the attached Physical/Immunization Form.

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."**

AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

Child's Name:_____ DOB:_____

I,_____, being the parent and/or legal guardian of the above mentioned child, grant permission to the Ballston Area Community Center 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 School-Age Child Care Program.

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

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 BACC employees, volunteers 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

Date of last tetanus shot:_____

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICATION CONSENT FORM

CHILD DAY CARE PROGRAMS

- This form may be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays.
- Only those staff certified to administer medications to day care children are permitted to do so.
- One form must be completed for each medication. Multiple medications cannot be listed on one form.
- Consent forms must be reauthorized at least once every six months for children under 5 years of age and at least once every 12 months for children 5 years of age and older.

LICENSED AUTHORIZED PRESCRIBER COMPLETE THIS SECTION (#1 - #18) AND AS NEEDED (#33 - 35).

1. Child's First and Last Name:	2. Date of Birth:	3. Child's Known Allergies:
4. Name of Medication *(including strength)*:	5. Amount/Dosage to be Given:	6. Route of Administration:

7A. Frequency to be administered: _____

OR

7B. Identify the symptoms that will necessitate administration of medication: *(signs and symptoms must be observable and, when possible, measurable parameters)*: _____

8A. Possible side effects: ☐ See package insert for complete list of possible side effects *(parent must supply)*

AND/OR

8B: Additional side effects: _____

9. What action should the child care provider take if side effects are noted:

☐ Contact parent ☐ Contact health care provider at phone number provided below

☐ Other *(describe)*: _____

10A. Special instructions: ☐ See package insert for complete list of special instructions *(parent must supply)*

AND/OR

10B. Additional special instructions: *(Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situation's when medication should not be administered.)* _____

11. Reason for medication *(unless confidential by law)*: _____

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and requires health and related services of a type or amount beyond that required by children generally?

☐ No ☐ Yes If you checked yes, complete (#33 and #35) on the back of this form.

13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered?

☐ No ☐ Yes If you checked yes, complete (#34 -#35) on the back of this form.

14. Date Health Care Provider Authorized:	15. Date to be Discontinued or Length of Time in Days to be Given:
16. Licensed Authorized Prescriber's Name (please print):	17. Licensed Authorized Prescriber's Telephone Number:

18. Licensed Authorized Prescriber's Signature:

X

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICATION CONSENT FORM

CHILD DAY CARE PROGRAMS

PARENT COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? *(For example, did the licensed authorized prescriber write 12pm?)* ☐ Yes ☐ N/A ☐ No

Write the specific time(s) the child day care program is to administer the medication *(i.e.: 12 pm)*: _____

20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to *(child's name)*:

21. Parent's Name *(please print)*:	22. Date Authorized:

23. Parent's Signature:

X

CHILD DAY CARE PROGRAM COMPLETE THIS SECTION (#24 - #30)

24. Program Name:	25. Facility ID Number:	26. Program Telephone Number:

27. I have verified that (#1 - #23) and if applicable,(#33 - #36) are complete. My signature indicates that all information needed to give this medication has been given to the day care program.

28. Staff's Name *(please print)*:	29. Date Received from Parent:

30. Staff Signature:

X

ONLY COMPLETE THIS SECTION (#31 - #32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN (#15)

31. I, parent, request that the medication indicated on this consent form be discontinued on _____ (Date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent Signature:

X

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #35)

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.

34. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date you are ordering the change in the administration of the prescription to take place.

DATE: _____

By completing this section, the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

35. Licensed Authorized Prescriber's Signature:

X