Haysville Recreation Before & After School Latchkey Enrollment Information

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To enroll your child(ren) for the HRD Latchkey Program for the school year (2021-2022), you need to do the following:

1. Pay the **$35 registration fee**/child and first week's fee. The registration fee is NOT refundable. Fees are based on enrollment not attendance!

2. Weekly fees are due by 6:00pm on the Friday PRIOR to the next week; payments are made in advance of the service provided. Payments received after Friday will be charged a $5 late fee. If payment is not received by the following Wednesday (the week of attendance) your child will not be able to attend again until payment is made in full.

3. All the attached paperwork must be completed and returned to the HAC before your child(ren) can attend. This includes the enrollment information, health history, authorization for emergency medical care and dispensing medication form (if needed). The Authorization for Emergency Medical Care form does not have to be notarized but the witness signature does need to be signed and dated.

4. All latchkey children must be picked up no later than 6:00pm. Any parent arriving late will be charged $1 for each minute per child he/she is late. CHILDREN WILL NOT BE ALLOWED TO RETURN UNTIL THE FEE IS PAID.

5. Sign the acknowledgement of Latchkey Policies.

⇨ Registration forms and fees are only taken at:

Haysville Activity Center
523 Sarah Lane
Haysville, KS 67060

⇨ If you have any questions, please call the HAC at 529-5922.

Enrollment $____ Week $____
Receipt # _______ Date ______
Start Date _______ Staff_____
Amount $____ Ck#___ CC___
Paid By: ___

HAYSVILLE RECREATION LATCHKEY ENROLLMENT FORM 2021-2022

Child's Name ______________________________ Age __________

Grade ______ Date of Birth ________________ Sex ______________

Registered Attendance		AM/PM Only	Both	School Attending (CIRCLE)
______	1 Day/Week	**$15**	**$20**	Freeman
______	2 Days/Week	**$25**	**$30**	Nelson
______	3-5 Days/Week	**$35**	**$45**	Ruth Clark
				Oatville
______	Mornings Only			Rex
______	Afternoon Only			Prairie
______	Both Before and After School			

Parent/Guardian (Mother) ________________________________
Address ______________________ City/Zip ______________________
Employer ____
Phone Numbers Cell ______________________ Work ______________________
Home __________________ Email Address ______________________________

Parent/Guardian (Father) ________________________________
Address ______________________ City/Zip ______________________
Employer ____
Phone Numbers Cell ______________________ Work ______________________
Home __________________ Email Address ______________________________

Lives With: Both Mother & Father:_____ Mother ONLY:_____ Father ONLY:_____
Split Custody: _____ Other:_____ If Other, Specify Whom:____________________

Emergency Contacts authorized to pick up your child(ren) (Other than Parents or Guardian)

1.______________________________ Relation:________________ Phone:______________
Address: ______________________________ City: ____________ State: ______ Zip: ________
2.______________________________ Relation:________________ Phone:______________
Address: ______________________________ City: ____________ State: ______ Zip: ________
3.______________________________ Relation:________________ Phone:______________
Address: ______________________________ City: ____________ State: ______ Zip: ________
4.______________________________ Relation:________________ Phone:______________
Address: ______________________________ City: ____________ State: ______ Zip: ________

(Continued……)

Acknowledgement of Latchkey Policies

At the time of initial enrollment, the **registration fee ($35)** and the first week's fees must be paid in full.

Weekly fees are due by 6:00pm on the Friday PRIOR to the next week; payments are made in advance of the service provided. Payments received after Friday will be charged a $5 late fee. If payment is not received by the following Wednesday (the week of attendance) your child will not be able to attend again until payment is made in full.

FEES ARE BASED ON ENROLLMENT, NOT ATTENDANCE. You will be required to pay for the days you have enrolled for, even if you do not use them, until you drop from the program at the HAC. **Fee adjustments will NOT be made due to sick/absent days, early school dismissals, school cancellations for weather and/or no school days.** Fees will be adjusted the week of Thanksgiving and the last week of school accordingly; you will be responsible for payment even if your child(ren) does not attend. **NO CREDITS ARE GIVEN FOR DAYS OF SCHOOL THAT ARE MISSED OR THAT THE CHILD DOES NOT ATTEND.**

All latchkey children must be picked up no later than 6:00pm. Any parent arriving late will be charged $1 per minute per child that he/she is late. CHILDREN WILL NOT BE ALLOWED TO RETURN UNTIL THE FEE IS PAID. If latchkey staff are unable to contact a responsible party after 30 minutes, the Haysville Police Department will be contacted. If parents are late more than three times, their child will be dismissed from the program. Official time will be kept by the site's cell phone.

My signature below acknowledges that I understand the above enrollment, late fee, fee adjustment and pick-up policies and that I have received a copy of the latchkey parent handbook.

Signature of Responsible Party: ______________________________ **Date:** __________

HRD Staff Signature: ______________________________________ **Date:** __________

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Rev. 5/2020

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 #**

I authorize ______________________________ (*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:

____

____

____

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: ______________

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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.

Haysville Recreation

523 Sarah Lane
Haysville, KS 67060
316-529-5922

Childs Name ____________________________ School ____________________ AM PM

Credit/Debit Card Latchkey Payment Plan Authorization Form

You can pay your child's weekly latchkey payments with a simple automated payment plan. It's easy to set-up and your payments will take care of themselves. Just complete and sign the form below to get started!

Here's How the Payment Plan Works:
We decide upon a mutually agreeable number of payments and a schedule. You authorize the regularly scheduled charges to your credit/debit card. A receipt will be emailed for each payment that includes information on amount paid and your next scheduled payment amount and date.

Please complete the information below:

Payment Amount: __________ Payment Frequency: ______________________________

Start Date: ______________________________ End Date: May 14, 2022

I ________________________________ authorize Haysville Recreation Department to charge my account indicated below to discharge the above debt for your children's latchkey program, using installment payments in the amount and schedule indicated. *****I understand if my credit/debit card rejects/declines for any reason, my account will be assessed an additional $5.00 processing fee/late fee.*****

Billing Address _____________________________________ Phone# ____________________________

City, State, Zip _____________________________________ Email ____________________________

SIGNATURE ____ DATE _______________________

I understand that this authorization will remain in effect until the debt is fully discharged or I cancel it in writing which ever comes first, and I agree to notify the Haysville Recreation Department in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment date falls on a holiday (like New Years Day), I understand that the payment may be executed on the next business day. ****In the case of a credit/debit card transaction being rejected or declined for non-sufficient funds (NSF) or for incorrect or non-updated information I agree to an additional $5.00 charge for each attempt returned or declined, which will be initiated as a separate transaction from the authorized recurring payment (thus basically being accessed a late fee).** I acknowledge that the origination of credit/debit card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit/debit card account and will not dispute Haysville Recreation Department billing with my credit/debit card company; so long as the transaction corresponds to the terms indicated in this agreement.

(The below information will be discarded after it is entered into the system...card information will NOT be stored!)

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Credit/Debit Card

____Visa ____ Mastercard ____ AMEX ____ Discover

Cardholder Name ______________________________ Account Number ______________________________

Expiration Date ______ CVV (3 digit code on back of card) _____ *Zip Code ___________
*(*must **match** card or will reject)*