Dunedin Parks & Recreation
Before/After School Program Information

Please keep this sheet for your records.

Prerequisites for BASP Registration :

New forms are required every school year. Forms must be filled out completely with **NO BLANK SPACES.** Parents are required to complete the following for each child enrolled:

1. Comprehensive Liability Waiver
2. Child Enrollment Record (**Changes may only be made in person by legal guardians.)**
3. Release for Emergency Care Form (must be notarized).
4. Influenza Brochure.
5. Food Experience Permission Form.
6. Medication Record Form if your child requires any type of medication, including non-prescription medications.
7. Parents will also need to complete "Promise Time" forms required by the Juvenile Welfare Board; signed by both parent and child(ren).
8. **Parents of VPK children** must submit a copy of their VPK child's current immunization records and health exam before they can attend. These may be obtained by your family physician or possibly the school your child will be attending.

Registration:

A $25 per child enrollment fee, the first payment plus any prorated days are due at the time of registration.

The annual fee to attend the program full time is divided into ten monthly payments; advance payments are accepted at any time. Part Time and Sporadic Care are available as needed, please contact the Registration Office for details at 727-812-4530 or Registration@dunedinfl.net.

Payments are due by the 1st of each month. Payments received after the 1st of each month will be charged a $10 late fee. Students whose balance has not been paid by the 3rd of each month cannot be admitted into the program. Thank you for your understanding and cooperation.

After the initial registration, payments can be made during open hours at the centers listed below or online. **Payments cannot be accepted at the Before/After School Program sites or by phone.**

Changes to the Enrollment Record must be made in person by a legal guardian. It is vital to keep all phone numbers and addresses current for the safety of your child.

You may enroll in our Before/After Care program at the Centers below during the hours listed:

Location: Dunedin Community Center
1920 Pinehurst Rd.
Dunedin, FL 34698
727-812-4530

Registration Hours: Mon –Thurs: 8 AM – 9PM
Fri: 8 AM – 6PM
Sat: 7 AM – 4PM

Location: MLK Jr. Recreation Center
550 Laura Lane
Dunedin, FL 34698
727-738-2920

Registration Hours: Mon – Fri: 2PM – 9PM
Sat: 12 PM – 8PM

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City of DUNEDIN Parks & Recreation

BEFORE/AFTER SCHOOL PROGRAM

Below are some important policies and guidelines found in the BASP Parent Handbook. Please read carefully before printing your name and signing in the space provided below.

If you have any questions, please don't hesitate to ask us.

- **BILLING**: The billing cycle runs the 1st through the end of the month with payment being due on the 1st. Balance due for the upcoming month is put on your account by the 20th of each month. Payment is considered late by the 2nd, and children can no longer attend on the 3rd. Payments can only be made in person or online. Parents are welcome to make payments in advance, call 727-812-4530 or email Registration@dunedinfl.net to have the balance put on your account prior to the 20th.

- **BILLING CHANGES:** Requests to change programs or attending days for Part Time care **must be made in writing**, prior to the 20th of each month. Changes will not be made after the month begins. Email your request to: Registration@dunedinfl.net. Any change to program enrollment will result in a $20 admin fee per request. Parents may transfer one drop-in enrollment without charge.

- **CANCELATIONS/REFUNDS: If your child will no longer attend the program a written cancellation request is required.** No refunds or prorations will be granted after the month begins, medical exceptions may apply. You must hand deliver or email your request to: Registration@dunedinfl.net.

- **LATE PICK UP FEES:** If your child is not picked up on time, a late fee will be charged as outlined in the parent handbook.

- **SIGN-OUT PROCEDURE:** All Changes to the pick-up list must be made in writing, including emergency situations. Phone calls to notify staff of an alternate pick-up person are not permissible.

- **ACCURACY:** It is the responsibility of the parent/guardian to ensure that the child's Enrollment Record and emergency contact information are accurate and remain up to date. These forms can only be updated in person by a legal guardian.

- **TEXT MESSAGE & EMAIL COMMUNICATION:** By providing your email, mobile number and carrier below, you agree to receive notifications about program changes, payments and other relevant information pertaining to activities in which you are enrolled. Message and data rates may apply.

Please read through the Parent Handbook provided for more important information.

Print Name: _____ **Date:** _____

Signature:_____

Email Address: _____

Mobile Number:_____ **Carrier:**_____

(Required for Text Messaging)

Updated: 6/06/23 BB

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CHILD'S ENROLLMENT RECORD

STAFF USE ONLY
Enrollment Date: _____
Program Start Date: _____

Child's full legal name_____
First *Middle* *Last* *Nickname*

Date of Birth_____ **Sex**_____

Primary Hours of Care From_____To_____ **Days of Week in Care**_____

Child's Physical Address_____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Family Information: **Child Lives with**_____

Parent's Name_____ Parent's Name_____

Address:_____Address_____

_____ _____

Home Phone:_____ Home Phone:_____

Employer:_____Employer:_____

Address:_____Address:_____

_____ _____

Work Phone_____Cell_____Work Phone_____Cell_____

Custody: Mother_____Father_____ Both_____ Other_____ Name_____

Emergency Contacts:
Child will be released only to the custodial parent or legal guardian and the persons listed below. The following people will also be contacted and are authorized to remove the child from the children's center in case of illness, accident or emergency, **if for some reason the custodial parent(s) or legal guardian(s) cannot be reached:**

Name_____

Home Phone_____Cell Phone_____

Address_____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Name_____

Home Phone_____ Cell Phone _____

Address_____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Please use additional sheet of paper to list name, address and phone number of any other people authorized to pick the child up.

CONTINUED ON BACK

CHILD'S ENROLLMENT RECORD

(Back Page)

Medical Information:

Child's Physician/Health Resource _____

Telephone Number _____

Address _____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Hospital Preference _____

Name of Dentist _____ Telephone _____

Address _____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Meals typically served while in care: ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper

Emergency Care Plan instructions (if applicable) _____

_____

_____

_____

MISCELLANEOUS INFORMATION

List all known allergies _____

_____

List all identifying scars, birthmarks, skin discolorations _____

Special medical or dietary needs of child _____

_____

List any areas of concern _____

_____

My signature below verifies that:

I give permission to consult the child's physician/health resource listed above in case of emergency if parent/legal guardian cannot be reached.

I have received a copy of the "Know Your Child's Children's Center" brochure.

I was notified in writing of the disciplinary and expulsion policies used by the children's center.

I was provided the food and nutrition policies used by the children's center.

Your signature below indicates that you have received the above items and that the information on this enrollment form is complete and accurate. I hereby grant permission for the staff of this facility to have access to my child's records.

_____

Signature of Custodial Parent or Legal Guardian **Date**

EMERGENCY MEDICAL RELEASE

This form must contain only one child's name, and be the original notarized form.

A new notarized form is required when there is a change in legal guardianship.

Please Print Information

Child's Full Name:_____ Birthdate:_____

Allergies:_____

Medicines Routinely Taken:_____

Name of Custodial Parent(s)/Legal Guardian(s):_____

Address:_____ _____ _____ _____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Home Telephone _____ Cell Telephone_____ Work Telephone _____

Family Physician's Name/Health Care Resource:_____

Address:_____ _____ _____ _____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Telephone (___)_____

Hospital Preference:_____
Name *City*

Medical Insurance Company:_____

Policy #:_____ Expiration Date:_____

Emergency Contact (if custodial parent/guardian cannot be reached**):**_____

Address:_____ _____ _____ _____
Street Address (number, apartment #, street) *City,* *State,* *Zip Code*

Home Telephone _____ Cell Telephone _____ Work Telephone _____

Sign in the presence of the Notary.

I hereby give my consent to any emergency facility and physician to administer necessary treatment to my child _____, in the event of an emergency at which time
(Child's Full Name)
I cannot be reached. I give consent to transport by ambulance if situation warrants it.

_____
Signature of Custodial Parent/Legal Guardian (Affiant)

STATE OF FLORIDA COUNTY OF _____

The foregoing instrument was acknowledged before me this _____ _____ 20_____
(Month) *(Day)* *(Year)*

by means of ☐ physical presence or ☐ online notarization by _____ who is personally known
(Name of Affiant)

to me or has produced _____as identification.
(Type of identification)

SEAL OF NOTARY

Signed:_____(*Signature of Notary)*

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Food Experience Permission Form

I give permission for my child _____ to participate in food related activities.

Please check one of the following:

○ My child DOES NOT have a food allergy or dietary restriction.

○ My child DOES have a food allergy or dietary restriction. He or she may participate, but may not eat or handle the following items (please list below)

_____

_____

☐ My child DOES have a food allergy or dietary restriction. He or she may not participate in activities.

_____ _____

Parent Signature Date

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During the 2009 legislative session, a new law was passed that requires child care facilities, family day care homes and large family child care homes provide parents with information detailing the causes, symptoms, and transmission of the influenza virus (the flu) every year during August and September.

My signature below verifies receipt of the brochure on *Influenza Virus, The Flu, A Guide to Parents:*

Name:_____

Child's Name: _____

Date Received:_____

Signature:_____

Please complete and return this portion of the brochure to your child care provider, in order for them to maintain it in their records.

What should I do if my child gets sick?

Consult your doctor and make sure your child gets plenty of rest and drinks a lot of fluids. Never give aspirin or medicine that has aspirin in it to children or teenagers who may have the flu.

CALL OR TAKE YOUR CHILD TO A DOCTOR RIGHT AWAY IF YOUR CHILD:

- Has a high fever or fever that lasts a long time
- Has trouble breathing or breathes fast
- Has skin that looks blue
- Is not drinking enough
- Seems confused, will not wake up, does not want to be held, or has seizures (uncontrolled shaking)
- Gets better but then worse again
- Has other conditions (like heart or lung disease, diabetes) that get worse

How can I protect my child from the flu?

A flu vaccine is the best way to protect against the flu. Because the flu virus changes year to year, annual vaccination against the flu is recommended. The CDC recommends that all children from the ages of 6 months up to their 19th birthday receive a flu vaccine every fall or winter (children receiving a vaccine for the first time require two doses). You also can protect your child by receiving a flu vaccine yourself.

What can I do to prevent the spread of germs?

The main way that the flu spreads is in respiratory droplets from coughing and sneezing. This can happen when droplets from a cough or sneeze of an infected person are propelled through the air and infect someone nearby. Though much less frequent, the flu may also spread through indirect contact with contaminated hands and articles soiled with nose and throat secretions. To prevent the spread of germs:

- Wash hands often with soap and water.
- Cover mouth/nose during coughs and sneezes. If you don't have a tissue, cough or sneeze into your upper sleeve, not your hands.
- Limit contact with people who show signs of illness.
- Keep hands away from the face. Germs are often spread when a person touches something that is contaminated with germs and then touches his or her eyes, nose, or mouth.

When should my child stay home from child care?

A person may be contagious and able to spread the virus from 1 day before showing symptoms to up to 5 days after getting sick. The time frame could be longer in children and in people who don't fight disease well (people with weakened immune systems). When sick, your child should stay at home to rest and to avoid giving the flu to other children and should not return to child care or other group setting until his or her temperature has been normal and has been sign and symptom free for a period of 24 hours.

For additional helpful information about the dangers of the flu and how to protect your child, visit: http://www.cdc.gov/flu/

What is the influenza (flu) virus?

Influenza ("the flu") is caused by a virus which infects the nose, throat, and lungs. According to the US Center for Disease Control and Prevention (CDC), the flu is more dangerous than the common cold for children. Unlike the common cold, the flu can cause severe illness and life threatening complications in many people. Children under 5 who have the flu commonly need medical care. Severe flu complications are most common in children younger than 2 years old. Flu season can begin as early as October and last as late as May.

How can I tell if my child has a cold, or the flu?

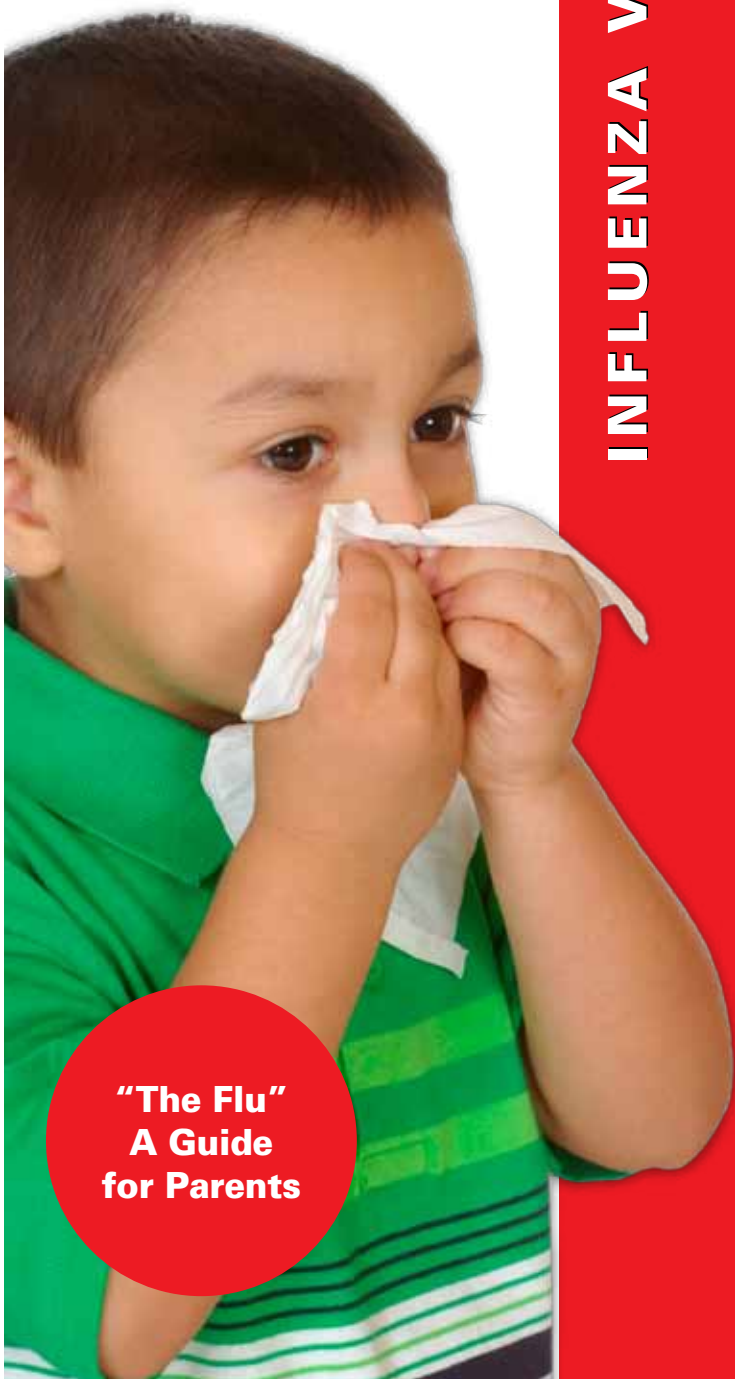
Most people with the flu feel tired and have fever, headache, dry cough, sore throat, runny or stuffy nose, and sore muscles. Some people, especially children, may also have stomach problems and diarrhea. Because the flu and colds have similar symptoms, it can be difficult to tell the difference between them based on symptoms alone. In general, the flu is worse than the common cold, and symptoms such as fever, body aches, extreme tiredness, and dry cough are more common and intense. People with colds are more likely to have a runny or stuffy nose. Colds generally do not result in serious health problems, such as pneumonia, bacterial infections, or hospitalizations.

Florida Department of Children & Families

For additional information, please visit www.myflorida.com/childcare or contact your local licensing office below:

CF/PI 175-70, June 2009

This brochure was created by the Department of Children and Families in consultation with the Department of Health.



"The Flu" A Guide for Parents

INFLUENZA VIRUS

Authorization and Consent for Disclosure,
Receipt, and Use of Confidential Information
by the Juvenile Welfare Board of Pinellas County

I, _____
_____ (*print participant name(s)*)
acknowledge that I am a participant of _____(*name of program or service*). I acknowledge that the Juvenile Welfare Board of Pinellas County ("JWB") provides funds to make the program or service in which I am participating available. I also acknowledge that in order to make sure that all services delivered to participants are of the highest possible quality, JWB may need to review information about me and these services.

By signing this Authorization, I am indicating that I understand and agree that my confidential information may be contained in a JWB data collection system, and that this data collection system is exempt from disclosure under the Florida Public Records Act. This means that by law, JWB cannot release individually identifiable information about me or the services I receive (Fla. Stat. §119.071). I acknowledge that as necessary to carry out the purposes listed herein, JWB may review all information about me, including my participant file and all other information pertaining to me held by the agency providing the program or service, regardless of whether that information is entered into a JWB data collection system. I further acknowledge that JWB is simply storing and reviewing records and information as the payor for these services, and that JWB generally provides no direct services to me, except in certain circumstances may facilitate service delivery I further acknowledge that JWB does not provide medical diagnoses to me and JWB is not a covered entity as that term is defined under HIPAA (the Health Insurance Portability and Accountability Act).

I authorize JWB to utilize my confidential information to verify eligibility for funded services or programs, to facilitate service delivery, make payment for services rendered to me by funded programs or services, quality control of funded services or programs, evidence-based research of JWB funded services or programs, including, but not limited to, tracking outcomes of funded programs and services, and determination of future services/programs funded by JWB. I understand that the confidential information disclosed, received or used by JWB related to my Authorization will not be further disclosed to any other party without my express written consent or as otherwise permitted or required by applicable law unless it is presented in a report that presents information on a group of individuals in de-identified format, which means that no information that identifies me as an individual is revealed.

I acknowledge that this Authorization covers all information about me including, but not limited to, personally identifiable information, Protected Health Information, general medical, general counseling, as well as psychiatric/ psychological/ substance abuse information from my medical health record, any information concerning the performance of any tests, results of those tests, and counseling and treatment records, as allowed by all state, federal and local laws, including, but not

limited to the following: Florida Statutes 394.459, 381.004, and 395.3025; Florida Evidence Code 90.503, 90.5035, and 90.5036; HIPAA, and the Code of Federal Regulations (CFR) Title 42. I consent to my minor participating in online or paper surveys that will be used for program improvements and enhancements. I understand that my records have a privileged and confidential status. I am waiving that status for the purposes contained by this Authorization.

I understand that the confidential information disclosed, received or used by JWB based on this Authorization will not be further disclosed to any other party without my express written consent or as otherwise permitted or required by applicable law. However, the individually identifiable confidential information received by JWB based on this Authorization may be used by JWB and its agents for research purposes, so long as the research results are reported as a whole in de-identified format, which means that no information that identifies me as an individual is revealed. Except, JWB will not provide any records covered by CFR Title 42 to any JWB agents.

I understand that I have the right to withdraw my approval in writing at any time. However, it is possible that JWB may have already relied on this Authorization before it receives notice of my withdrawal and that JWB may have already taken action based on the Authorization. If I do not withdraw my approval, it will automatically end one (1) year from the last day I received services from this program, or with respect to information used in research, or for compliance and quality review activities performed by JWB or its agents, upon completion of the last research project or compliance/ quality review, whatever occurs latest. By my signature below, I acknowledge that I have given my consent as indicated above freely, voluntarily, and without coercion, and that I have been given a copy of this authorization, signed by me on the date shown below.

_____ _____

Witness Signature Date

_____ _____

(print participant name) Signature of Participant or Participant's Authorized Representative (check one):

○ Participant ○ Parent ○ Guardian

_____ ○ Personal Representative (Legal Documents Required)

Effective Date

______________________ (print participant name)	______________________ Signature of Participant or Participant's Authorized Representative (check one):
______________________ Effective Date	○ Participant ○ Parent ○ Guardian ○ Personal Representative (Legal Documents Required)
______________________ (print participant name)	______________________ Signature of Participant or Participant's Authorized Representative (check one):
______________________ Effective Date	○ Participant ○ Parent ○ Guardian ○ Personal Representative (Legal Documents Required)
______________________ (print participant name)	______________________ Signature of Participant or Participant's Authorized Representative (check one):
______________________ Effective Date	○ Participant ○ Parent ○ Guardian ○ Personal Representative (Legal Documents Required)
______________________ (print participant name)	______________________ Signature of Participant or Participant's Authorized Representative (check one):
______________________ Effective Date	○ Participant ○ Parent ○ Guardian ○ Personal Representative (Legal Documents Required)
______________________ (print participant name)	______________________ Signature of Participant or Participant's Authorized Representative (check one):
______________________ Effective Date	○ Participant ○ Parent ○ Guardian ○ Personal Representative (Legal Documents Required)

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Site Name: _____

CHILD INFORMATION SHEET

This form is for data gathering purposes only. The information is not shared or used for any other purpose and is kept strictly confidential as required by the City of Dunedin, the Juvenile Welfare Board of Pinellas County, and Pinellas County Schools. We look forward to providing you and your child with the best in childcare services.

Child Information

Name *(First, Middle Initial, Last)*: _____

- Please Print –

Date of Birth *(mm/dd/yy)*: ____/____/____ **Sex**: ❑ Male ❑ Female **Relationship to Head of Household:** _____

Home Address: _____ **City:** _____ **Zip Code:** _____

New or returning? ❑ New ❑ Returning **Gender:** ❑ Male ❑Female ❑Trans Male ❑Trans Female ❑ Gender Non-Conforming

Does your child speak a language other than English at home? ❑ Yes ❑ No If yes, primary language spoken: _____

Race

❑ American Indian or Alaska Native
❑ Asian
❑ Black, African American
❑ Haitian
❑ Multiracial
❑ Native Hawaiian
❑ Other Asian (Hmong, Laotian, Thai, Pakistani, etc.)
❑ Other Pacific Islander (Fijian, Tongan, etc.)
❑ White
❑ Some other race: (Please specify)_____

Ethnicity

❑ No, not of Hispanic, Latino, or Spanish Origin
❑ Yes, Cuban
❑ Yes, Mexican, Mexican American, or Chicano
❑ Yes, Puerto Rican
❑ Yes, another Hispanic, Latino, or Spanish Origin

School Information

Please provide the following information for the current school year.

School Name: _____

Current Grade Level: _____

IEP ❑ Yes ❑ No **504 plan** ❑ Yes ❑ No **IAP** ❑ Yes ❑ No

Pinellas County Student ID: _____

Household Composition

❑ Dual Parent - Married
❑ Dual Parent - Non-Married, Female Head of Household
❑ Dual Parent - Non-Married, Male Head of Household
❑ Single Parent - Female Head of Household
❑ Single Parent - Male Head of Household
❑ Other-Relative/Kinship Care: Dual Parent - Married
❑ Other-Relative/Kinship Care: Single Parent - Female Head of Household
❑ Other-Relative/Kinship Care: Single Parent - Male Head of Household
❑ Other Non-Relative (*such as guardian, foster parent, family friend, etc.)*
❑ Unknown

Household Information

Annual Household Income $_____ *(before taxes)*

Number of People in Household:

_____Adults _____Children

_____Children over age 18 if in special needs program

Siblings

Please list any other children attending:

Site: _____ Child's Name: _____

Site: _____ Child's Name: _____

Site: _____ Child's Name: _____

Parent Information - *please print neatly*

Last Name: _____ **First Name:** _____

Home Phone: (____) _____ **Cell Phone:** (____) _____

Email Address: _____

How did you hear about us? _____

Why did you choose us?

❑ Activities ❑ Price
❑ Convenience or location ❑ Reputation
❑ Curriculum ❑ Safety/Supervision
❑ Previous children enrolled ❑ Staff
❑ Referral by school, family member, or friend ❑ Special offer / discount
❑ Other

I certify the information provided on this form is true and complete to the best of my knowledge:

Parent/Guardian Signature: _____ **Date:** _____

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Juvenile Welfare Board
Investing in children. Strengthening our community.

Site: Dunedin Parks & Recreation
Promise Time
Participant and Parent/Guardian
Statement of Commitment

The Promise Time initiative is a learning center program for students that offers a variety of stimulating activities to promote school success and personal well-being in a safe environment. **Active attendance and engagement are essential to the students' progress and program's success.**

I understand the activities of the Promise Time program include:

- Youth will complete pre- and post-assessments to monitor their progress and help in the youth's curriculum plan.
- Youth will participate in tutoring and online activities to improve in their academics.
- Youth will participate in programming related to project-based learning activities with an emphasis on reading, science and/or math skills, as provided.

I have read and understand the activities listed above.

_____ _____
(Parent or Guardian Signature) **Date**

_____ _____
(Youth Signature) **Date**

REQUIRED

This section is to be completed by parent or guardian and center director or supervisor in charge of Promise Time

I, _____ parent/guardian of _____ give my permission for the
(Print parent/guardian name) **(Print youth name)**
staff of this OST program, located at this school, to share my child's enrollment in this OST program with the schools. I also agree to all the staff of this OST program, located at this school, to review my child's academic and behavior progress reports or their report cards in order to document growth and progress in my child during his/her time in this program. This includes information about whether my child has an identified exceptionality, an Individual Education Plan or Academic Improvement Plan, and suggestions from my child's teacher(s) on how my child can best be helped in the program.

_____ _____ _____ _____
Parent/Guardian Signature **Date** **Director Signature** **Date**