

Dunedin Parks & Recreation

Before/After School Program Information

Registration begins at 8 AM on Wednesday, July 22, 2020. Registration must be done in person at the Dunedin Community Center by the Parent or Legal Guardian. 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. Child Enrollment Record (**Changes may only be made in person by legal guardians.**)
2. Release for Emergency Care Form (must be notarized).
3. Influenza Brochure.
4. Food Experience Permission Form.
5. Medication Record Form if your child requires any type of medication, including non-prescription medications.
6. COVID19 Acknowledgement of Liability
7. **Parents of Pre-K children** must submit a copy of their Pre-K 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.
8. **Parents of San Jose and Dunedin Elementary only** will also need to complete "Promise Time" forms required by the Juvenile Welfare Board; *signed by both parent and child(ren).*

Registration:

A \$25 per child enrollment fee and the first payment is 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.

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 Community Center (1920 Pinehurst Road) the Martin Luther King, Jr. Recreation Center (550 Laura Lane) 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 Dunedin Community Center during the hours listed below:

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

Registration Hours: Mon –Thurs: 8 AM – 7:30PM
Fri: 8 AM – 5:30PM
Sat: 8 AM – 12:00PM



CHILD'S ENROLLMENT RECORD

| |
|----------------------------|
| DIRECTOR'S USE ONLY |
| Date enrolled _____ |

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.



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 I cannot be reached. I give consent to transport by ambulance if situation warrants it.

(Child's Full Name)

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)



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

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.



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.



INFLUENZA VIRUS

**“The Flu”
A Guide
for Parents**

DUNEDIN

Parks & Recreation

Acknowledgement of Risks and Waiver of Liability Relating to Coronavirus/COVID-19

I acknowledge that on or about March 11, 2020, Coronavirus Disease 2019 ("COVID-19") was declared a pandemic by the World Health Organization. The Centers for Disease Control and Prevention ("CDC") has stated that "the best way to prevent illness is to avoid being exposed to this virus."

<https://www.cdc.gov/coronavirus/2019-ncov/prepare/prevention.html>.

I am aware of the contagious nature of COVID-19 and have voluntarily chosen to allow my child(ren) to participate in programs operated by the City of Dunedin Parks & Recreation Department.

I acknowledge that City of Dunedin employees come into contact with multiple individuals, and might become exposed to COVID-19. I also acknowledge that although the City of Dunedin takes precautions to reduce the likelihood of transmission of COVID-19 by its employees, the City of Dunedin cannot guarantee that my child(ren) will not become infected with COVID-19.

I knowingly acknowledge that by allowing my child(ren) to participate in the City of Dunedin's programs, I am exposing my child(ren) and myself to the risk of becoming infected with COVID-19, which may result in serious personal injury, illness, permanent disability, and death. I understand the risk of becoming exposed to or infected by COVID-19 may result from actions, negligence, and failures to act of myself and others, including, but not limited to, the City of Dunedin employees, and other program participants and parents.

I agree to assume all of the foregoing risks, and accept personal responsibility for any injury to my child(ren) or myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability or expense, of any kind or nature, that I may suffer arising out of or in connection with my child(ren) or myself becoming exposed to or infected by COVID-19 while my child(ren) is/are participating in any City of Dunedin program. On my own behalf, and on behalf of my child(ren), I hereby release, covenant not to sue, and forever discharge the City of Dunedin, its employees, agents, and representatives, of and from all liabilities, claims, actions, damages, costs or expenses of any nature ("Claims") arising out of or in any way connected with my child(ren) or myself becoming exposed to or infected by COVID-19. I understand that this release includes any Claims based on the negligence, action, or inaction of any of the City of Dunedin, its employees, agents, and representatives, and covers bodily injury (including death) due to COVID-19, whether a COVID-19 infection occurs before, during or after participation in any City of Dunedin program.

Parent or Guardian's Signature: _____ Date: _____

Parent or Guardian's Name Printed: _____

Child(ren)'s Name (first & last): _____

DUNEDIN
Home of Honeymoon Island
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 to have the balance put on your account prior to the 20th.
- **REFUNDS:** No refunds will be granted after the month begins, medical exceptions may apply.
- **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 is accurate and remains 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 BASP information.

Print Name: _____ **Date:** _____

Signature: _____

Email Address: _____

Mobile Number: _____

Carrier: _____

(Required for Text Messaging)

**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)

 Effective Date

 Signature of Participant or Participant's
 Authorized Representative (check one):
 Participant Parent Guardian
 Personal Representative (Legal Documents
 Required)

(print participant name)

Effective Date

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

- Participant Parent Guardian
- Personal Representative (Legal Documents
Required)

(print participant name)

Effective Date

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

- Participant Parent Guardian
- Personal Representative (Legal Documents
Required)

(print participant name)

Effective Date

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

- Participant Parent Guardian
- Personal Representative (Legal Documents
Required)

(print participant name)

Effective Date

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

- Participant Parent Guardian
- Personal Representative (Legal Documents
Required)

(print participant name)

Effective Date

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

- Participant Parent Guardian
- Personal Representative (Legal Documents
Required)

Grant Participant Information Form



(Office use only)

Member ID # _____

Program Entry Date _____

Closing Date _____

Annual Review _____ _____

Our agency receives funding from Juvenile Welfare Board for the program that has or will serve your child. In return for this funding, we agree that our program will be evaluated by The Juvenile Welfare Board. All information will be kept confidential and will be used only for the purpose of evaluating the program and measurable outcomes.

School Site: _____

Child's Name: _____ Birth date: _____ Age: _____ Male Female

Address _____ City: _____ Zip Code: _____

School Attending: _____ Current Grade: _____ 10-Digit Student ID #: _____

Who has Legal Custody: _____ Relationship to Child: _____

Parent/Legal Guardian's Name: _____

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Place of Employment: _____

Parent/Legal Guardian's Name: _____

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Place of Employment: _____

Total Number of Children in Household: _____ Total number of Adults in Household: _____

Household Arrangement: (select one) Single Parent - Female head of household Single Parent - Male head of household

Dual Parent - Married Dual Parent - Non-married Female head of household Other - Non-relative

Dual Parent - Non-married Male head of household Other - Relative/Kinship Care - Male head of household

Other - Relative/Kinship Care - Female head of household Other Relative/Kinship Care - Married

Gross yearly combined Household Income: \$ _____

Participant's Lunch Status: Full Reduced Free Is participant a Foster Child: Yes No

Race: (select one) White Black African American American Indian or Alaska Native Asian Indian

Chinese Filipino Japanese Korean Vietnamese Native Hawaiian Guamanian or Chamorro

Samoan Asian, Unspecified Other Asian (Hmong, Laotian, Thai, Pakistani, Cambodian, etc.)

Other Pacific Islander (Fijian, Tongan, etc.) Some other Race Multi Racial

Ethnicity: (select one) No, Not Hispanic, Latino or Spanish Yes, Mexican, Mexican American or Chicano

Yes, Puerto Rican Yes, Cuban Yes, Another Hispanic/Latino or Spanish Origin

I certify that all information documented on this form regarding myself and my child is true and complete to the best of my knowledge. I fully understand that any omissions, falsifications or misrepresentations may disqualify my child from participating in the City of St. Petersburg and The Juvenile Welfare Board Matched Partnership Grant Program.

Signature of Custodial Parent/Legal Guardian (Affiant): _____

