

Date Application Completed _____

Date of Enrollment _____

**Afterschool Enrichment Program
CHILD'S APPLICATION FOR ENROLLMENT**

To be completed, signed and placed on file in the facility on the first day and updated as changes occur.

CHILD INFORMATION:

Full Name _____
Last First Middle Nickname

Child's Physical Address: _____
Street City Zip Code

Elementary School _____ Grade as of Fall _____ K 1 2 3 4 5 Birthdate _____
(circle one)

Shirt Size (Circle one): Youth S (6-8) Youth M (10 – 12) Youth L (14 – 16) Youth XL (16 – 18) Adult size _____

FAMILY INFORMATION:

Father/Guardian's Name _____ Home Phone _____

Address (if different from child's) _____ Zip Code _____

Work Phone _____ Cell Phone _____ Email _____

Mother/Guardian's Name _____ Home Phone _____

Address (if different from child's) _____ Zip Code _____

Work Phone _____ Cell Phone _____ Email _____

CONTACTS:

Child will be released only to the parents/guardians listed above. The child can also be released to the following individuals, as authorized by the person who signs this application. In the event of an emergency, if the parents/guardians cannot be reached, the facility has permission to contact the following individuals.

Name Relationship Address Phone Number

Name Relationship Address Phone Number

Name Relationship Address Phone Number

REGISTRATION & PAYMENT

There is a yearly, non-refundable, registration fee of \$50. After paying the registration fee, you will receive notice of additional paperwork due. All paperwork is due by August 1st to hold your child's space.

Tuition is 10 payments of \$290, due on the 15th of the month beginning in August. Tuition covers all School Days and *Camp Days from the first day of school in August until the last day of school in June, according to the CMS & Union County Calendar, with the exception of any days posted on the COSKids calendar that we are closed for business.

*Camp Days are those days which CMS or Union County Schools are closed, but COSKids is normally open.

I understand that a space will be reserved for my child, when available, once my registration payment and paperwork have been turned into the Main Office. I understand that I am responsible for paying in full on the 15th of each month, with a late fee added after the 18th.

Parent/Guardian Signature _____ Date _____

TURN OVER ...

HEALTH CARE NEEDS:

For any child with health care needs such as severe allergies, asthma, diabetes, seizures or other chronic conditions that require specialized health services, a medical action plan shall be attached to the application. The medical action plan must be completed by the child’s parent or health care professional. Is there a medical action plan attached? ___ YES ___ NO

List any allergies and the symptoms and type of response required for allergic reactions. _____

List any health care needs or concerns, symptoms of and type of response for these health care needs or concerns. _____

List any particular fears or unique behavior characteristics the child has. _____

List any types of medication taken for health care needs. _____

Share any other information that has a direct bearing on assuring safe medical treatment for your child. _____

EMERGENCY MEDICAL CARE INFORMATION

Name of health care professional _____ Phone _____
Hospital Preference _____ Phone _____

I, as the parent/guardian, authorize COSKids to obtain medical attention for my child in an emergency.

Parent/Guardian Signature _____ Date _____

I, as the operator, do agree to seek emergency transportation to an appropriate medical resource in the event of emergency. In an emergency situation, other children in the facility will be supervised by a responsible adult. I will not administer any drug or medication without specific instructions from the physician or the child’s parent, guardian, or fulltime custodian.

Administrator’s Signature _____ Date _____

ADDITIONAL INFORMATION

Please provide any information concerning your child which will be helpful in his/her experience in group settings, such as any specific likes/dislikes, fears, habits or needs. _____

What does your child enjoy doing when inside? _____

What does your child enjoy doing outside? _____

Does your child have any special interests or talents? _____

Information updated on: _____	Signed: _____	Information updated on: _____	Signed: _____
Information updated on: _____	Signed: _____	Information updated on: _____	Signed: _____
Information updated on: _____	Signed: _____	Information updated on: _____	Signed: _____



ASEP Routine Transport Permission

(Schools where children are picked up by the COSKids Bus or Van)

I _____ give permission for _____
(parent/guardian's name) (child's full name)
to be transported to COSKids' campus, located at 226 West John Street, Matthews, NC from their
school: _____
(name of school)

Method of travel: COSKids' activity bus or van

Transportation Provider: COSKids (Christ Our Shepherd Ministries)

Permission to transport is valid from _____ to _____ (up to 12 months).

Signature of Parent/Guardian _____ Date _____

Signature of Director of Afterschool _____ Date _____

Transport from Matthews Elementary School

Children are transported to COSKids from Matthews Elementary using CMS buses. Every summer parents must complete an Alternate Stop Request Form. These forms DO NOT automatically carry over from year to year. This form is located on the CMS Transportation webpage. We will make an effort to notify families when these forms become available each summer.

CHILDREN'S MEDICAL REPORT

Name of Child _____ Birth date _____

Name of Parent or Guardian _____

Address of Parent or Guardian _____

A. Medical History (May be completed by parent)

1. Is child allergic to anything? No ___ Yes ___ If yes, what? _____

2. Is child currently under a doctor's care? NO ___ Yes ___ If yes, for what reason? _____

3. Is the child on any continuous medication? No ___ Yes ___ If yes, what? _____

4. Any previous hospitalizations or operations? No ___ Yes ___ if yes, when and what for? _____

5. Any history of significant previous diseases or recurrent illness? No ___ Yes ___; diabetes No ___ Yes ___;

Convulsions No ___ Yes ___; heart trouble No ___ Yes ___; asthma No ___ Yes ___

If others, what/when? _____

6. Does the child have any physical disabilities: No ___ Yes ___ If yes, please describe: _____

Any mental disabilities? No ___ Yes ___ If yes, please describe: _____

Signature of Parent or Guardian _____ **Date** _____

B. Physical Examination: This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the N.C. Board of Medical Examiners (or a comparable board from bordering states), a certified nurse practitioner, or a public health nurse meeting DHHS standards for EPSDT program.

Height _____ % Weight _____ %

Head _____ Eyes _____ Ears _____ Nose _____ Teeth _____ Throat _____

Neck _____ Heart _____ Chest _____ Abd/GU _____ Ext _____

Neurological System _____ Skin _____ Vision _____ Hearing _____

Results of Tuberculin Test, if given: Type _____ date _____ Normal ___ Abnormal ___ followup _____

Developmental Evaluation: delayed _____ age appropriate _____

If delayed, note significance and special care needed: _____

Should activities be limited? No ___ Yes ___ If yes, explain: _____

Any other recommendations _____

Date of Examination: _____

Signature of authorized examiner/title _____ **Phone #** _____

Child Immunization History

Child's Name _____ Date of Birth _____

Instructions: Enter each date of each dose received (Month/Day/Year) **or** attach a copy of the immunization record. G.S. 130A-155(b) requires child care facilities to file this information. Please refer to page 2 for the Minimum State Vaccine Requirements for Child Care Entry and the additional Vaccines Recommended by the Advisory Committee on Immunization Practices.

Vaccine Type	Vaccine Abbreviation	Trade Name	Combination Vaccines	1	2	3	4	5
Diphtheria, Tetanus, Pertussis	DTaP, DT, DTP	Infanrix, Daptacel	Pediarix, Pentacel, Kinrix					
Polio	IPV, OPV	IPOL	Pediarix, Pentacel, Kinrix					
Haemophilus influenza type B	Hib	Act HIB, Pedvax HIB **	Pentacel					
Hepatitis B	HepB, HBV	Engerix-B, Recombivax HB	Pediarix					
Measles, Mumps, Rubella	MMR	MMR II	Proquad					
Varicella/Chicken Pox	Var	Varivax	Proquad					
Pneumococcal Conjugate*	PCV, PCV-13, PPV-23	Prenvar, Pneumovax***						

Legend:

*Required by state law for children born on or after 7/1/2015.

** 3 shots of Pedvax HIB are equivalent to 4 Hib doses. 4 doses are required if a child receives more than one brand of Hib shots.

***Pneumovax is a different vaccine than Prenvar and may be seen in high risk children.

Note: Children beyond their 5th birthday are not required to receive Hib or PCV vaccines.

Gray shaded boxes above indicate that the child should not have received any more doses of that vaccine.

Record updated by:	Date	Record updated by:	Date

Minimum State Vaccine Requirements for Child Care Entry

By This Age:	Children Need These Shots:						
3 months	1 DTaP	1 Polio		1 Hib	1 Hep B	1 PCV	
5 months	2 DTaP	2 Polio		2 Hib	2 Hep B	2 PCV	
7 months	3 DTaP	2 Polio		2-3 Hib**	2 Hep B	3 PCV	
12-16 months	3 DTaP	2 Polio	1 MMR	3-4 Hib**	3 Hep B	4 PCV	1 Var
19 months	4 DTaP	3 Polio	1 MMR	3-4 Hib**	3 Hep B	4 PCV	1 Var
4 years or older (in child care only)	4 DTaP	3 Polio	1 MMR	3-4 Hib**	3 Hep B	4 PCV	1 Var
4 years and older (and in kindergarten)	5 DTaP	4 Polio	2 MMR	3-4 Hib**	3 Hep B	4 PCV	2 Var

Vaccines Recommended by the Advisory Committee on Immunization Practices (ACIP), But NOT Required

Vaccine Type	Vaccine Abbreviation	Trade Name	Recommended Schedule	1	2	3	4	5
Rotavirus	RV Rota	Roteteq Rotarix	2 months, 4 months, 6 months					
Hepatitis A	Hep A	Havrix Vaqta	12-23 months, then another dose within 6-18 months					
Influenza	Flu	Fluzone Fluarix FluLaval Fluvirin FluMist Afluria	Annually after 6 months of age					

Communication Notice

Be sure to add the following **email** addresses to your address book so you never miss an a message:



NFulwood@coskidsmatthews.org (Afterschool)

DSand@coskidsmatthews.org (Childcare & Billing)

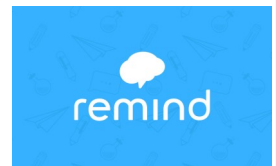
CJackson@coskidsmatthews.org (Childcare)

RHavican@coskidsmatthews.org (Billing)

Sign up for **text messaging alerts** from COSKids Childcare:

Text this message: @coskids

To: 81010



Join COSKids **Facebook Group**:

<https://www.facebook.com/groups/coskids>



You will have to request access to the group.

Handbook Acknowledgement & Behavior Contract

Thank you for helping us maintain a Christ-centered, positive, safe environment at COSKids ASEP.

- I have received and read the Parent Handbook for COSKids' ASEP
- I have read and discussed the behavior expectations with my child as outlined in the handbook.
 - My child will be expelled or withdrawn, without a refund, if he/she endangers the health or welfare of him/herself, another child, or the facility.
- I understand that COSKids' will not be held responsible for any lost or damaged items brought from home, including electronic devices.
- I understand that my child should wear appropriate clothing and shoes to ASEP and Camp Days.

Parent/Guardian #1 (Print name): _____

Signature: _____ Date: _____

Parent/Guardian #2 (Print name): _____

Signature: _____ Date: _____

As your child's ASEP Director and Group Leader, we promise to:

- Listen to your child and respond to his/her needs.
- Communicate clear, consistent expectations for behavior.
- Model love for God and neighbor, honesty, respect, responsibility, courage, forgiveness, self-control, humility, kindness, and perseverance.

Summer Camp Director (Print name): _____

Signature: _____ Date: _____

Group Leader (Print name): _____

Signature: _____ Date: _____

COSKids After School Enrichment Program Homework Response Form



COSKids' After School Enrichment Program provides a positive, relaxed atmosphere where your child(ren) can unwind after a long day at school. We understand that in many instances families prefer that homework is the priority during ASEP.

Our schedule includes 1 hour of homework time Monday – Thursday. All students are expected to spend this time doing homework, reading or other quiet activities. We cannot offer one-to-one supervised reading time (where the students read aloud to an adult), and therefore we do not sign reading logs. We encourage you to read with your child at home. We will offer extended homework time if needed, according to staff availability.

Please discuss the following options with your child and indicated your decision regarding homework during the ASEP hours.

Student's Name: _____ Class: _____

_____ I would like my child to complete as much of his/her homework as possible while at COSKids ASEP.

_____ I would like my child to have the choice of whether or not to do homework while in ASEP, with the understanding that he/she will be expected to either read or do other quiet activities during the designated time.

_____ I do not want my child to do homework while in ASEP. I prefer that homework is completed and home, with the understanding that he/she will be expected to either read or do other quiet activities during the designated time.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Please explain any difficulties your child may have doing homework.

Are there any subjects that your child needs particular help with? What means of help have been successful in the past?

Please provide any additional information that may help us to help your child with homework.

Walking Permission Form



I give my permission for my child to walk with his/her group leader:

_____ Outside the playgrounds and within the constraints of John St., Trade St., Ames St. and Charles St.

_____ To/from and play on the back playground

_____ To/from both the Main and Upper Buildings on campus including the library, gym and game room

Photo Permission Form

I give COSKids my permission to take pictures of my child for the purpose of:

_____ Classroom displays and projects

_____ Uploading to COSKids' closed Facebook group without any child specific information

_____ Promotions such as COSKids websites, Facebook page, flyers or brochures, without any child specific information



This authorization is valid from ____/____/____ to ____/____/____ (12 months maximum)

Child's full name: _____

Parent's name: _____

Signature: _____ Date: _____

Childcare Law Summary Acknowledgement

I, _____ (Parent/Guardian name), have read the summary of NC Child Care Laws and Regulations provided by COSKids.

Child's full name: _____

Parent's name: _____

Signature: _____ Date: _____