Family Network After School Activity Program (ASAP)

2014-2015 Consent Form and Emergency Contact Information

Child's Name: _____ **Birth date**: _____/_____/_____ **Sex**: Male Female

Address: _____ **City**: _____ **Zip**: _____

School Attending (circle one): Indian Trail | Lincoln | Oak Terrace | Ravinia | Wayne Thomas

Grade in 2014-15 School Year: _____

Enrolled for (circle days): Monday Tuesday Wednesday Thursday Friday

	Parent/Responsible Party	**Parent/Responsible Party**
Name		
Relationship to Child		
Home Phone		
Business Phone		
Cell Phone		
Email Address		
Home Address		
Business Address		
Working Hours		

Legal Guardian: _____Work Phone: _____Cell Phone: _____
Step Parent: _____Work Phone: _____Cell Phone: _____

EMERGENCY and RELEASE INFORMATION: The following information is for use in case of emergency and for everyday pick-up release information. We will attempt to notify parents first. Please list in order of priority, people willing to pick-up your child during the program hours. **Please complete all sections.** Contact us with any changes in writing. In case of serious illness, parents will be called and instructed to meet their child and a staff member at the nearest hospital.

Child ***CAN*** be released to (Please list individuals **other than parents/legal guardian** and step parent listed above):

Name	**Relationship to Child**	**Address**	**Phone (Home & Cell)**
1.			( ) ( )
2.			( ) ( )
3.			( ) ( )
4.			( ) ( )

Child ***CANNOT*** be released to:

Name	**Relationship to Child**	**Address**	**Phone**
1.			( )
2.			( )
3.			( )

I give permission for my child _____ to receive emergency medical treatment which may include, but is not limited to, first aid by staff, care by paramedics, physician or local hospital. I understand that I am responsible for any costs incurred.

_____ _____
Signature Date

_____ _____
Print Name Relationship to Child

Doctor(s) Name/Practice: _____Phone: _____

Address: _____ Hospital Affiliation_____

Child's Dentist _____Phone: _____

I have informed the ASAP director and staff of all medical and emergency information pertaining to my child. I give permission to the school nurse to provide a copy of the emergency medical information for my child.
(Please Print) Student Name: _____

Parent Signature: _____ Date _____

Allergies (include food, medication, insects, etc.): _____

_____

Any additional physical/mental health information or other special needs including academic deficits:
_____

_____

PHOTO
I give the Family Network After School Activity Program (ASAP) permission to use photos of (student name) _____or other family members (parent and sibling names) _____ in publications or for publicity informational purpose. I understand that Family Network owns rights to the photos.

EXCURSIONS and Field Trips
I/We authorize ASAP staff or agents to take my child/ren on walking trips, excursions and field trips. They may travel in any vehicle leased by ASAP. I understand that I will receive notification prior to any fieldtrip and have the right to refuse authorization for my child to go on the fieldtrip.

RELEASE OF LIABILITY FOR MINORS
I understand that Family Network's After School Activity Program (ASAP) is attempting at all times to exercise reasonable caution and I do not hold them responsible for accidental injury occurring while my child is attending the program. I hereby expressly forever waive, release and discharge the Family Network After School Activity Program (ASAP) and their representatives from all such liabilities, claims, demands, injuries, damages, rights of action, or cause of action, whether the same be known or unknown, anticipated or unanticipated.

_____ _____
Guardian Signature One Date

_____ _____
Print Name Relationship to Child

_____ _____
Guardian Signature Two Date

_____ _____
Print Name Relationship to Child

Return to: Bobbie Hinden, ASAP Director
Family Network | 330 Laurel Avenue | Highland Park, IL 60035
Email: bobbie.hinden@family-focus.org | Phone: 847.433.0377 Fax: 847-433-0461

Family Network After School Activity Program (ASAP)
2014-2015 MONTHLY TUITION AND FEES POLICY FORM

Application

A $25 application fee for returning families and a $50 application fee for new ASAP families is due at time of registration.

Monthly fee

- The monthly fee is based upon a **total yearly cost and divided into nine equal monthly payments.**
  $336/5 days per week - $284/4 days per week - $220/3 days per week
- ASAP closings – Thanksgiving Break, Winter Break, Spring Break – no change in tuition during those months. Calendar to follow.
- Tuition is payable on the 15th of the previous month (first payment due August 15th for September). **The August 15th payment must be received before your child can attend ASAP.**
- Fee adjustments **will not** be made for early pick up or days not attended.
- A sliding fee scale is available for families needing assistance.

Full Days, Early Dismissal Days, and No Show Fees

- Full Day fees must be paid the month **following** the full day; it will appear on the invoice.
- Early dismissal days do not incur an extra charge for those children already registered on that day. ASAP children not normally attending on an early dismissal day may come for an additional $25; staff must be notified in advance of the day.

Delinquent Payments – IMPORTANT!

- Monthly tuition is due by the 15th of the month prior to the month of attendance. (For example, September tuition is due by August 15th).
- If current tuition is not received at that time, a **$20 late fee will be charged**. Parents are responsible for paying tuition for the entire period during which their children are enrolled.
- **Fees not paid by the end of the month will result in your child missing ASAP until arrangements for payment have been made. Please call director to discuss payment issues.**

Refunds

- If a child is absent from school (illness, vacation, etc) that does not coincide with times when the ASAP program is closed, the parent is **still responsible** for tuition payments during that period of time.
- To withdraw your child from the program, Family Network must receive notification either in writing or by phone to the ASAP Director. Refunds will be issued in full if the request to withdraw is made prior to the beginning of the month.

NSF Checks

- A $25 fee will be assessed for each check returned due to non-sufficient funds.

I have read and agree to comply with this policy. Name (Please Print) _____
Parent Signature _____ Date _____

Please complete both sides of this form.

Family Network
a family focus center

330 Laurel Ave.
Highland Park, IL 60035

2014-2015
After School Activity Program
ASAP

INVOICE PREFERENCES

Name(s) of child or children_____

CHOICES (choose one):

CHARGE CREDIT CARD FOR TUITION

☐ Please charge my:
☐ Visa ☐ Master Card ☐ American Express

Card Number _____ Exp. Date _____

Card Holder's Signature _____

Please automatically charge tuition to my credit card on the 15th of the month (August 15, 2014 – July 15, 2015, if necessary):

Signature: _____

MAIL INVOICES

☐ Please mail invoices to:

Name _____

Address _____

City _____

Zip Code _____

EMAIL INVOICES

☐ Please email invoices to:

Name _____

Email _____

FAMILY NETWORK - AFTER SCHOOL ACTIVITY PROGRAM (ASAP)
330 Laurel Ave. Highland Park, IL 60035 (847) 433-0377

2014-2015 CONFIDENTIAL PARENT OBSERVATION SURVEY

The best place to gather information about children is from their parents. The observations you make as your son or daughter grows are valuable to us as providers of after school care. Please take a few moments to answer the questions below so that the ASAP staff can best meet the needs of your child.

Child's Name _____ **Nickname** _____

Grade _____ **Birth date** _____

School (circle one): Indian Trail | Lincoln | Oak Terrace | Ravinia | Wayne Thomas | Sherwood

1. Please list all of the adults and children living in your child's household:

First and Last Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

2. Does your child speak or understand a language other than English? Yes No
If yes, what language? _____

3. What are your child's major strengths?

4. What does your child like to do with his/her free time? What would both of you like to see us offer at ASAP?

5. How does your child get along with other children?

6. How important is it for your child to do his/her homework while attending ASAP? What is your child's attitude with respect to homework?

7. Describe any fears your child may have.

8. Please describe recent family events or changes (i.e. death, divorce, new sibling, moving).

9. How do you feel the ASAP staff can best help your child this year? Please tell us anything else we should know.

10. Please inform us if your child has any special needs. An IEP? Behavior challenges?

11. In order to best serve your child, do you give permission for the ASAP Director or the Site Coordinator to confer with school personnel?

The questions above were answered by _____ Date _____

Please return to: Bobbie Hinden, ASAP Director
Family Network 330 Laurel Ave. Highland Park, IL 60035
Ph: 847-433-0377 Fax: 847-433-0461
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