KATHY DAHNKE

From: LORI MARTIN
Sent: Tuesday, August 1, 2017 9:42 AM
To: KATHY DAHNKE
Cc: ILIANA BEZARES-VAZQUEZ
Subject: Bergman BLAST Enrollment

Great News! I am happy to report that our Community Learning Center Grant has been funded for the 20117-18 school year! This means that we will be able to continue to offer Bergman **BLAST** program!

BLAST stands for Bergman Learning in After School Time. **BLAST** provides quality learning experiences in a fun setting for our students from 7:30 to 8:30 in the morning and 3:40 to 5:30 each day. Ms. Iliana Vazquez will be serving as our new BLAST Director, and has many exciting activities planned for our Bergman students!

Attached you will find the enrollment forms and fee schedule for Bergman **BLAST**. You will also find these forms available as a link on our school's website and when you attend Bergman Building Enrollment . Please feel free to contact Ms. Vazquez here at school at 785-587-2865 Extension: 3287 or via email at ilianab@usd383.org.

It is time to **BLAST** off to for a great school year!
Lori Martin
Principal

Bergman Learning in After School Time

Dear Parents,

Welcome to the academic school year 2017-2018 session of BLAST. We strive to offer programming that will interest your child and help him/her academically, socially, and physically.

The program starts on August 16, 2017 and will end on May 24, 2018. Breakfast and an afternoon snack will be provided for all children participating in the program.

BLAST will convene at 7:30 am and our afternoon program at 3:40 pm, and finishes at 5:30 pm Monday through Friday.

Students will receive an enrollment packet, which must be filled out and returned to the school office, classroom teacher, or BLAST coordinator.

A sliding fee schedule is attached. Please make checks payable to USD 383. Fees received after the fifth of each month will be assessed a $5.00 late charge. There is a $30.00 charge for any returned checks. **FEES ARE NON-REFUNDABLE.**

Parents who choose to pick up their child after 5:30 pm will be charged $1.00 for each minute the child is left past closing time. This fee is to be paid before the child returns to after school programs.

All students **MUST** have a current medical health form on file in the BLAST office. This form is included in the enrollment packet.

Please contact Ms. Iliana Vazquez at (785) 587-2865 or ilianab@usd383.org if you need further information.

Iliana Bezares-Vazquez
BLAST Coordinator

USD 383 Manhattan - Ogden

2017 -2018 School Year

K- 6 Before and After School Program

Fee Schedule

Before School Only: 20 hours monthly average 7:30 a.m. - 8:30 a.m. $106

After School Only: 40 hours monthly average 3:40 p.m. - 5:30 p.m.

Household Income***	$0-$15,000	$15,001-$22,000	$22,001-$26,000	$26,001-$28,000	$28,001-$34,000	$34,001-$44,000	$44,001-$55,000	$55,001-$69,999	$70,000 & above
Family pays									
1st child	$ 38.00	$ 44.00	$ 50.00	$ 58.00	$ 93.00	$ 110.00	$ 165.00	$ 172.00	$ 188.00
Each add'l child	$ 34.00	$ 40.00	$ 45.00	$ 53.00	$ 83.00	$ 98.00	$ 148.00	$ 158.00	$ 163.00

Before AND After School: 60 hours monthly average 3:40 p.m. - 5:30 p.m.

Household Income***	$0-$15,000	$15,001-$22,000	$22,001-$26,000	$26,001-$28,000	$28,001-$34,000	$34,001-$44,000	$44,001-$55,000	$55,001-$69,999	$70,000 & above
Family pays									
1st child	$ 52.00	$ 63.00	$ 69.00	$ 76.00	$ 111.00	$ 129.00	$ 184.00	$ 194.00	$ 206.00
Each add'l child	$ 50.00	$ 57.00	$ 62.00	$ 70.00	$ 100.00	$ 116.00	$ 165.00	$ 174.00	$ 185.00

****Proof of income required for ALL members contribting to household.**** Fees are due on the first of each month.

Checks are made payable to USD 383.

A $5.00 late charge will be added after the 10th of the month unless other arrangements are made.

A $30.00 fee will be charged for any returned checks.

DCF Assistance is available for those who qualify. Ask Ms. Vazquez for further information

Fall

~~Spring~~ 2017 **Verification for After School Fee Payment**

Important! Important! This document should be filled out in its entirety.

HOUSEHOLD MEMBERS				GROSS INCOME BEFORE ANY DEDUCTIONS				
	List Names of ALL Household Members earning wages. Household member includes anyone living at this address		Check if ZERO Income	Frequency: Circle ONE next to each income amount: W = Weekly, E2=Every 2 weeks, 2M=Twice a Month, M=Monthly, Y=Yearly				Check if NOT working due to strike, lay-off, injury or short term disability
				Earnings from Work		***Other Regular Income		
	First Name	Last Name		Amount	Circle Frequency	Amount	Circle Frequency	
1			☐	$	W E2 2M M Y	$	W E2 2M M Y	☐
2			☐	$	W E2 2M M Y	$	W E2 2M M Y	☐
3			☐	$	W E2 2M M Y	$	W E2 2M M Y	☐
4			☐	$	W E2 2M M Y	$	W E2 2M M Y	☐
5			☐	$	W E2 2M M Y	$	W E2 2M M Y	☐
6			☐	$	W E2 2M M Y	$	W E2 2M M Y	☐

Check if Foster Child	List Names of All Household Members Under the age of 18			
	First Name	Last Name	School Name	Grade
1 ☐				
2 ☐				
3 ☐				
4 ☐				
5 ☐				
6 ☐				

ADULT HOUSEHOLD MEMBER INFORMATION

Print Name _____ Daytime Phone _____ Evening Phone _____

Street Address _____ City _____ ZIP _____

Email _____

***Other Regular Income** includes the following: welfare, child support, alimony, retirement pensions, Social Security, Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), veteran's benefits (VA), disability benefits, regular contributions from people who do not live in your household, farming, rental income, and ANY OTHER INCOME.

I certify (promise) that information on this application is true and that ALL household income is reported. **I am providing proof of income (tax returns, W2, or pay stubs) to be used in verifying fee payment.** Purposely giving false information may result in your child(ren)'s dismissal from the after school program.

Sign Here X _____ Date _____

Frank V. Bergman Before/After School Program BLAST

2017-2018

This form must be filled out completely and signed before you child will be allowed to attend after school programs.

Student's Name _____ Grade ___ Teacher's Name_____

_____ My child will be picked up by 5:30 p.m. **Parents or authorized person(s) must come into the building to pick up their child(ren).**

The following person(s) has my permission to pick up my child(ren) after school. Please list ALL persons who might be picking up your child(ren).

Name(s)_____ Phone #'s_____

_____ My child can walk home from the After School Program.

_____ My child will be riding the bus from the After School Program.

Student Information: (Please print and complete all questions)

First Name: _____ Middle: _____ Last: _____

Gender: Female __ Male __ Birthdate: ___/____/_____ Age ___

Home Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Ethnicity: (circle all that apply)

African-American, Asian, Caucasian, Hispanic, Multi-Racial, Native American, Other

_____

_____ My child is from a military family

___ check if your child is on an IEP

_____ Check if your child receives free/reduced lunch

Emergency Contact Information

Mother/Stepmother/Guardian (circle one)
Name_____
Home phone _____
Place of Work _____
Work or cell phone _____
Email _____

Father/Stepfather/Guardian (circle one)
Name_____
Home Phone _____
Place of Work _____
Work or cell phone _____
Email _____

Children will not be dismissed from the After School Programs early unless the staff have received a written note or phone call.

Emergency Contacts: (other than parent or guardian who has permission to pick up child from BLAST)

Name_____ Phone _____ Cell _____
Relationship to child: _____
Name_____ Phone _____ Cell _____
Relationship to child: _

Health Form

(To be completed by Parent or Guardian)

Student's Name _____ Female ___ Male ___

Physician Name _____ Phone _____

Is child covered by insurance? Yes _____ No _____

Health History:

Does your child have asthma ___No ___ Yes Convulsions ___ No ___Yes

Diabetes ___ No ___ Yes

Other chronic or long-term illness (ex: ADHD) ___ No ___Yes

If illness, explain _____

Medications _____

Allergic Reactions: (Please list and explain any reactions)

Foods _____

Drugs/Medications _____ Insects _____

Plants _____ Animals _____

Hay Fever _____ Others _____

Any restrictions in activities

_____

Restrictions While Participating in After School Events:

Special Diet or Dietary Restrictions

_____

Special Activity Restrictions

_____

Past History of Serious Injuries or Illnesses

_____

Special Considerations Staff should know about _____

Parent's Authorization: In case of emergency I understand every effort will be made to contact our family's physician and me. In the event I cannot be reached, I give permission to the Ogden Summer School Program to secure proper medical treatment for my child. I give permission for my child to engage in all activities except as noted above.

_____ _____

Signature of Parent or Guardian Date

STUDENT CONTRACT

TO BE READ and SIGNED BY STUDENT AND PARENT

Students **MUST** have an enrollment form and health form filled out and on file in order to attend. The student and parent's signatures are **required** at the bottom of this form. **Please review this page with your child.**

1. Total participation is required to be a part of this program. All students are asked to come ready and willing to be an active participant in the chosen activity.
2. ALL STUDENTS WILL ALSO PARTICIPATE IN 15-30 MINUTES OF HOMEWORK/ODYSSEY EACH DAY.
3. Self-controlled discipline is part of the requirement to be in the After School Programs. All students are asked to follow the leader's instructions and procedures. The Six Pillars of Character are the guidelines for positive behaviors. All students are asked to follow the guidelines.
4. **Regular attendance is a requirement** for all students participating in the program. If a student is sick, he/she is automatically excused. We ask that you please send a note or call the school office or Mrs. Harrell if your child is to be excused from clubs. If a student chooses to quit a club, they may not transfer to another program until the next session. **Please notify Mrs. Harrell if your child chooses to no longer participate in a club(s).**

Parent Information: (please read, initial, and sign below)

1. I give permission for my child to participate in the activities of the After School Program. In case of emergency I understand that every effort will be made to contact me or the person(s) listed under the Emergency Contact section. In the event my contact(s) or I cannot be reached, I give permission to the After School Program to secure proper medical treatment, including hospitalization and any required surgery, for the member.
   Initial: ____
2. I understand that I am responsible for payment of any medical bills created by injury to the student during after school activities. **Initial:** ____
3. I give my consent for photographs/video, in which my son/daughter may appear, to be used in promotional materials for the After School Programs **Initial:** ____
4. A member cannot leave the school premises or activity without express permission or direction communicated to staff member from a parent/guardian. **Initial:** ____
5. I understand that I may be subject to a late fee if I am unable to pick up my child at designated closing time. **Initial:** ____

STUDENTS BEING PICKED UP WILL NOT BE DISMISSED UNLESS PARENTS COME TO THE MOBILE UNIT TO GET THEM.

FOR THE SAFETY OF ALL CHILDREN,

ANY PERSON WHO IS PICKING UP A CHILD IS ASKED TO SIGN OUT WITH A STAFF MEMBER. If the person is unknown to the staff or not listed on the permission form, parents will be called and identification required. PLEASE INFORM ALL PERSONS INVOLVED WITH YOUR CHILD TO ADHERE TO THIS POLICY.

Parent Signature _____

Student Signature _____

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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

Authorization for Dispensing Medications to Children and Youth
Long-Term Medications (Prescription and Non-Prescription)

Prescription medications must be in their original containers labeled with the child's or youth's first and last name, the date the prescription was filled, the name of the licensed physician or licensed nurse practitioner who wrote the prescription, the expiration date of the medication, and specific and legible instructions for administration and storage of the medication. Administer the medication according to the instructions. **Non-prescription medications** can be given by permission and direction from the parent, guardian or legal custodian based on general advice received from the child's or youth's physician. Administer nonprescription medication from the original container labeled with the first and last name of the child or youth and according to the instructions on the label. A record of administration must be kept.

First and Last Name of Child or Youth

Name of Medication (only one medication per authorization) Prescription OR Non Prescription

Reason for Medication

Dose Time to be Given **Start Date** **Stop Date****

Name of Licensed Physician or Nurse Practitioner prescribing the medication Phone # of Physician

I allow the above medication to be given to my child or youth by the child care provider/staff member or school age program staff member.

Parent's Signature Date Signed

**Stop date not to exceed one year from the start date. A new authorization is to be completed any time the medication, dosage, times to be given, or instructions from the parent or health care provider change from the information included on this form. Additional copies of this form may be attached to this page if more space is needed to record the administration of the medication for up to one year if there are no changes in instructions. Above information must be completed on each page but the parent's signature is required only once per year.

THIS FORM IS TO BE USED TO DOCUMENT ADMINISTRATION OF ONLY THE MEDICATION IDENTIFIED ABOVE. Provider or staff member to note any comments or remarks about the child's or youth's appearance and/or condition on the back of the form.

Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials

Each person administering medication is to sign on the back side of this form and identify initials used above.

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
Single Dose Only	DPT, DT*, TD (*DT only if child is allergic to DTP)	/ /	/ /	/ /	/ /	/ /
	POLIO	/ /	/ /	/ /	/ /	
	MMR	/ /	/ /			
	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
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?

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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 hereby authorize Iliana Vázquez - BLAST Coordinator (Name of individual/staff member) and/or Lori Martin-Bergman Principal (Name of individual/staff member) 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 _____ (First and Last Name of Child or Youth) while said child or youth is in said facility's custody between the dates of _____ (MM/DD/YYYY) and _____ (MM/DD/YYYY).

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: _____

List any known allergies or other information about the medical status of this child or youth pertinent in case of emergency:

_____

_____

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: _____

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.