BLAST

Bergman Learning in After School Time

FALL 2018

Student's Name _____ Grade in Fall 2018 ____

_____My child will ride the bus at 5:15

_____ My child may walk home from BLAST

_____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).**

Ethnicity: (circle one)
African-American Asian
Caucasian Hispanic
Multi-Racial Native American

Student Information: (Please print and complete all questions)

First Name: _____Last:_____

Gender: Female ___ Male ___ Birth Date: ____ / ____ / _____ Age ____

Emergency Contact Information

Mother / Stepmother / Guardian (circle one)
Name _____
Home phone _____
Place of work _____
Work or cell phone _____
E-mail _____

Father / Stepfather / Guardian (circle one)
Name _____
Home phone _____
Place of work _____
Work or cell phone _____
E-mail _____

For your child's safety, children will not be dismissed from BLAST early OR to another adult unless a written note or phone call has been received by the staff.

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

Name_____ Phone_____ Cell _____
Relationship to child: _____
Name_____ Phone_____ Cell _____
Relationship to child: _____

Health Form
Fall 2018

(To be completed by Parent or Guardian)

Student's Name _____Female __Male __

Parent's Name _____ Phone _____

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 BLAST 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-SCHOOL YEAR 2018-2019

TO BE READ and SIGNED BY STUDENT AND PARENT

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

BLAST STUDENT NAME (please print): _____

Grade level of student – Fall 2018: _____

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. 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.
3. **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 Ms. Iliana if your child is to be excused from clubs.
4. **Discipline and dismissal policy:** Students enrolled in BLAST will follow the Bergman Rubric. Consequences for inappropriate behavior will include, but not limited to, short-term program suspension, long-term program suspension, and/or complete program removal.

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

1. I give permission for my child to participate in the activities of BLAST. 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 for the BLAST personnel 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 BLAST program. **Initial:** _____
4. I give my consent for photographs/video, in which my son/daughter may appear, to be used on social media and/or the USD 383 web site. **Initial:** _____
4. A student 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:** _____.

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.

Please review these guidelines with your child on a regular basis at home.

Parent/Guardian Name (please print) _____

Parent Signature _____ **Date** _____

BLAST Director Signature _____**Date** _____

CCL 010
Rev. 6/2015

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) 296 -0803
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 #
Bergman BLAST	0026118-010

I hereby authorize Iliana Bezares-Vázquez (Name of individual/staff member) and/or Bergman Elementary (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 08/15/2018 (MM/DD/YYYY) and 05/23/2019 (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.

CCL. 358
Rev. 1/2014

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) 296-0803
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?

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

CCL.027
Rev. 5/2017

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/youth's first and last name; the name of the licensed physician, physician assistant (PA), or advanced practice registered nurse (APRN) who ordered the medication; the date the prescription was filled; the expiration date of the medication; and specific, legible instructions for administration and storage of the medication. Administer the medication only to the child designated on the prescription label in accordance with the instructions on the label. **Non-prescription medications** can be given with written permission and direction from the parent or legal guardian. Administer nonprescription medication from the original container labeled with the first and last name of the child/youth and according to the instructions on the label.

First and Last Name of Child/Youth — Date of Birth

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, PA or APRN prescribing the medication — Phone # of Physician, PA or APRN

I allow the above medication to be given to my child/youth by the designated person.

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. Designated Person to note any comments or remarks about the child's/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 designated person administering medication is to sign on the back side of this form and identify initials used above.**

*Signature of Designated Person Administering Medication _____ Initialing as_____

*Signature of Designated Person Administering Medication _____ Initialing as_____

*Signature of Designated Person Administering Medication _____ Initialing as_____

*Signature of Designated Person Administering Medication _____ Initialing as_____

Note Form

Date	Additional comments about the incident or other related incidents, including comments or remarks about the child's/youth's appearance and/or condition.

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Kansas Department of Health and Environment
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Topeka, KS 66612-1274
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Kansas
Department of Health and Environment

PARENTAL PERMISSION FORM FOR OFF-PREMISES TRIPS

Name of the Facility (exactly as stated on the license)			License #
Bergman BLAST			0026118-009
Street Address of the Facility	**City**	**Zip Code**	**County**
3430 Lombard Dr.	Manhattan	66503	Riley

______________________________ may go to the following locations off the premises **with** adult supervision:
First and Last Name of Child or Youth

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

FOR SCHOOL AGE CHILDREN OR YOUTH ONLY

I hereby authorize my **school age child** ______________________________

First and Last Name of Child or Youth **Birth Date MM/DD/YYYY**

To walk/bike to and from the following location(s) **without** adult supervision:

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Fall 2018 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** inludes 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 _____

USD 383 Manhattan-Ogden (1.30.09)

2018-2019 School Year

K-6 Before and After School Programs — Proposed Fee Schedule (subject to change)

Before School Only: 30 hours monthly average 7:30 a.m. - 8:30 a.m.	$106.00

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 contributing 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. Iliana for further information.