Winchester Recreation

263 Main Street
Winchester, MA 01890-3311
Phone: 781-721-7125
Fax: 781-721-7129

WRAP Program

The Recreation department would like to welcome you to the WRAP after school program for Kindergarten through Grade 5.

Enclosed please find The Winchester Recreation After-School Program Registration Packet.

All information must be fully completed and dated, we will not accept partial packets. Payment info: Tuition is paid a month in advance on the 1st of each month through automatic credit card payment only. First months tuition will be charged August 1. If you have any billing related questions. Please call the Recreation Office at (781) 721-7125. For program related questions, contact WRSP Director Carol McCollem at cmccollem@winchester.us

Winchester Recreation After-School Program
263 Main St
Winchester, MA 01890
781-721-7125
Enrollment Form

Child's Name:_____ Eye Color:_____ Skin Color:_____

Home Address:_____ Hair Color:_____ Height:_____

Telephone:_____ Sex:_____ Weight:_____

Date of Admission:_____ Age at Admission:_____

Date of Birth:_____ Primary Language:_____

Identifying Marks:_____

Allergies*/special diet:_____

If your child has Allergies additional forms must be filled out (Health Care Form Attached)

PARENT/GUARDIAN INFORMATION:

Parent/Guardian Name:	Parent/Guardian Name:
DOB:	DOB:
Relationship to Child:	Relationship to Child:
Home Address:	Home Address:
Home Telephone:	Home Telephone:
Cell Phone:	Cell Phone:
Email:	Email:
Work Name:	Work Name:
Work Address:	Work Address:
Work Phone:	Work Phone:

Medical Information

Child's Physician:
Phone #
Address:
Chronic Health Conditions (Medical, dietary, ADHD, auditory, etc): Yes No
Special Limitations or concerns:
I certify that documentation of physical examination and immunizations in accordance with public school health requirements, and lead poisoning screening in accordance with public health requirements are on file at my child's school. **Parent/Guardian Signature: _____Date:_____**

School your child is attending:
Grade:
Days your child will be attending: please check the days of the week they will be in attendance. We are a 3 or 5 day program*

- ☐ Monday
- ☐ Tuesday
- ☐ Wednesday
- ☐ Thursday
- ☐ Friday

Payment Authorization Form

SCHOOL YEAR

Date:_____

Child's Name:_____

Parent's Name:_____

Address:_____

Phone: Home_____ work_____ Cell_____

E-mail:_____

Program: (W.R.A.P./ASK) Winchester Recreation After-School Program)

I understand that the above program is to be paid on an automatic monthly payment basis and that the initial payment, which covers the first month of the program. Returning students, first month payment is due

The W.R.A.P. program's first payment will be taken out August 1, 2021. Any changes in care or withdrawals must be done 30 days in advance.

Please Initial_____

I authorize automatic monthly payments to be made to:

The Winchester Recreation Department After-School Program

Please circle one:

MasterCard Visa Discover

_____

Credit Card Number:_____

Expiration Date:_____

3 Digit Security Code (on back of card):_____

Signature:_____

Date:_____

If your billing address for your credit card is different than your property address please include information below

_____

_____

Individual Health Care Plan Form

(ONLY NEEDS TO BE FILLED OUT IF YOUR CHILD HAS A HEALTH CARE PLAN)

Plan must be renewed annually or when child's condition changes

Plan was created by: *Check all that apply*

- ☐ Parent
- ☐ Doctor or Licensed Practitioner
- ☐ Program's Health Care Consultant
- ☐ Older school age child (9+ years of age)

Plan is maintained by: *Check all that apply*

- ☐ Director
- ☐ Assistant Director
- ☐ Child's Educator
- ☐ Other:_____

Name of child:_____Date:_____

Any changes to the child's Health Care Plan?

Yes (indicate changes below) No (updated physician/parental signatures required)

Description of chronic health care condition:

Symptoms:

Medical treatment necessary while at the program:

Potential side effects of treatment:

Potential consequences if treatment is not administered:

Name of educators that received training addressing the medical condition:

Person who trained the educator (child's health Care practitioner, child's parent, program's Health Care Consultant)

Name of Licensed health Care Practitioner (print name)_____Date_____

Licensed Health Care Practitioner consent: _____Date_____

Parental/Guardian Consent:_____Date_____

For Older Children ONLY (9+ years of age)

With written parental consent and authorization of a licensed health care practitioner, this individual Health Plan permits older school age children to carry their own inhaler and /or epinephrine auto-injector an use them as needed without the direct supervision of an educator.

The educator is aware of the contents and requirements of the child's Individual Health Plan specifying how the inhaler or epinephrine auto-injector will be kept secure from access by the other children in the program. Whenever an Individual Health Care Plan provides for a child to carry his or her own medication. The licensee must maintain a back-up supply of the medication for use as needed.

Age of child:_____ Date of birth:_____ Back-up medication received? Yes__ or No_____

Parent Signature:_____Date:_____

Administrator's signature:_____Date_____

Transportation Plan and Authorization

Child's Name:_____

My child will arrive at the program by: (must check off)_

_____ SCHOOL BUS DROP OFF

_____ Parent/Authorized Drop Off

_____UNSUPERVISED WALK (5th and 6th Graders ONLY)

_____ SUPERVISED WALK with _____

My child will depart from the program by: (check all that apply)

_____ Parent/Authorized Pick Up

_____ UNSUPERVISED WALK (5th and 6th Graders ONLY)

_____ SUPERVISED WALK with _____

I give permission for my child to be released from the program at the end of the day as stated above and/or I give permission to the following people to receive my child at the end of the day.
(If no one is authorized, please indicate below by writing "**NO ONE**.")

1. Name:_____
Address:_____
Relationship:_____ Phone #:_____
2. Name:_____
Address:_____
Relationship:_____Phone #:_____
3. Name:_____
Address:_____
4. Name:_____
Address:_____
Relationship:_____Phone #:_____
5. Name:_____
Address:_____
Relationship:_____Phone #:_____
6. Name:_____
Address:_____
Relationship:_____Phone #:_____

Any other transportation requests must be stated in writing and maintained in the child's file or the above plan must be implemented. This permission is valid for one program year from the date of Signature.

_____

Parent/Guardian Signature Date_____

Off Site Activities, Media & Special Services Form

Child's Name:_____

OFF SITE ACTIVITIES PERMISSION:

I _____, give permission for my child to participate in all of the regularly scheduled on-going activities located at the following off site facilities "**please mark with an X**"

- ☐ Ginn Field
- ☐ Lincoln School Park
- ☐ Neighborhood Surrounding Mystic School
- ☐ Grounds of McCall Middle School
- ☐ Winchester Public Library

Parent/Guardian Signature_____Date:_____

MEDIA RELEASE INFORMATION:

I give permission for Winchester Recreation After -School Program to use images and/or written articles that mention my child _____ for the following purposes

(Mark an "X" for all that apply):

_____ In-House (e.g. Holidays, classroom bulletin boards, newsletters)
_____ Marketing material (e.g. Brochures & Winchester Recreation website) - photo and name
_____Marketing material - photo only
_____Newspaper - photo and name
_____ Newspaper - photo only
_____All of the above
_____None of the above (your child will NOT be allowed to take part in ANY IN-HOUSE media if you choose this option)

Parent/Guardian Signature_____Date_____

SPECIAL SERVICES:
Does your child receive special services? YES☐ NO☐

If yes, explain what services _____

Parent/Guardian Signature_____Date_____

SUNSCREEN

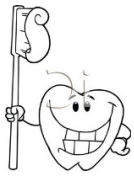
We expect that all children will arrive daily with sunscreen already applied. If during the course of the afternoon your child needs to reapply sunscreen they may do so independently. If your child will need assistance from a staff member, we must receive prior authorization to do so. You must send your child in with a bottle of sunscreen labeled with their name on it.

W.R.A.P. & ASK are only allowed to help your child reapply sunscreen if the following section is checked off and signed. If you do not wish for the staff to help your child apply sunscreen please check off the appropriate box.

☐ I hereby authorize The Winchester Recreation Staff to reapply sunscreen on my child as needed.

☐ I **do not** authorize The Winchester Recreation to apply sunscreen on my child.

Parent/Guardian Signature_____Date:_____



Tooth Brushing Authorization/Waiver

Child's Name_____ Date of Birth:_____

In January 2010, the Department of Early Education and Care (EEC)issued new regulations for child care programs that include a requirement that all educators assist children with brushing their teeth if they are in care for more than four hours or children have a meal while in care [606 CMR 7. 11(11)(d)]. This includes after school kindergarteners that attend more than four hours a day and on early release days. You are asked to provide a toothbrush for your child and replace it every three months or after an illness (i.e. strep throat)

As an EEC licensed program the Winchester Recreation must comply with this regulation. However, parents may choose to have their child **not participate** in tooth brushing while present at the Program.

Please fill out this form indicating whether your child will be participating in tooth brushing while present at the program. A separate form must be filled out for each child in care. This form must be renewed annually and will be kept in your child's folder here at the Program.

Please check one:

☐ I **do not** wish to wish to have my child participate in tooth brushing while in care at The Winchester Recreation

☐ I wish to have my child participate in tooth brushing while in care at The Winchester Recreation. I understand I am responsible for providing a toothbrush labeled with my child's name and replace it every three months or after an illness.

Parent/Guardian Signature_____Date:_____

Sledding Permission Form

Student Name:_____

I give permission for _____ to go to sledding during the winter months while he/she attends The Winchester Recreation After-School Program 2019-2020 school year. I understand that, in the event medical treatment is required, every effort will be made to contact me. However, if I cannot be reached, I give permission to The Winchester Recreation After-School Staff to provide my child with the utmost care needed.

Parent/Guardian Signature_____Date_____

Waiver of Liability Statement

I, the parent or legal guardian of the child listed below, release The Winchester Recreation After-School Program together with the staff in charge, from any and all claims resulting from injury or damage that may be sustained by my child while participating in the activities listed below.

Name of Student_____

Valid for Sledding during the winter months for School year 2021 - 2022

Parent/Guardian Signature_____Date_____

Teacher's Emergency Card

Child's Name_____**Date of Birth**_____

Address_____**Home/Cell Phone**_____

School _____**Grade**_____

Emergency Contacts (in order to be contacted)

1. **Emergency Contact 1**_____
   Cell Phone_____

   Employer & Town_____

   Work Phone_____
2. **Emergency Contact 2**_____
   Cell Phone_____

   Employer & Town_____

   Work Phone_____
3. **Emergency Contact 3**_____
   Cell Phone_____

   Employer & Town_____

   Work Phone_____

SIDE A

Child's Name_____

MEDICAL INFORMATION

***Physician*:**_____**Phone:**_____

Address:_____

Medical Insurance:_____**Plan#**_____

Date of Last Tetanus Immunization:_____

ALLERGERIES (CHECK THOSE APPLICABLE OR SPECIFY TYPE)

Penicillin Reaction_____**Food Allergies**_____

Bee Sting Reaction_____

Asthma_____**Other:**_____

SPECIAL HEALTH CONCERNS or MEDICAL CONDITIONS:

I confirm that my child has been examined by a physician within the last two years and that there are no apparent reasons for his/her not participating in routine physical activities.

I also give permission for my child to be transported to The Winchester Hospital for immediate attention if deemed necessary by the program staff and that, in case of injury or illness, emergency medical care may be administrated in the event that one of the contacts designated above cannot be reached promptly.

Parent/Guardian Signature_____**Date**_____

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM

Child's Name: _____ Date of Birth: _____

I authorize staff in the child care program who are trained in the basics of first aid/CPR to give my child first aid/CPR when appropriate.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and/or to _____, and to secure necessary medical treatment for my child.

Child's Physician Name: _____
Address: _____
Phone Number: _____
Child's Allergies: _____
Chronic Health Conditions: _____

Emergency Contacts (*In order to be contacted*)

Name_____
Address_____
Relationship to child_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No_____

Name_____
Address_____
Relationship to child_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No_____

Name_____
Address_____
Relationship to child_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No___
_____ _____

Health Insurance Provider:_____Policy#_____

Parent/Guardian Name:_____Phone: _____

Parent/Guardian Name:_____Phone: _____

_____ _____
Parent/Guardian Signature **Date (valid for one year)**