River City Believers Academy

After School Care Application

Child's Full Name_____ Date of Birth____/____/_____

Home Address_____City_____State____Zip_____

Parent's/Guardian's Name(s)_____

Mother's Telephone_____ Father's Telephone_____

Give the name, address, and phone number of a person to call is case of an emergency if the parent/guardian cannot be reached.

Name_____ Telephone _____

Address_____City_____State____Zip_____

_____*I hereby authorize the childcare operation to allow my child to leave the childcare operation ONLY with the following persons:*
(Please list name & telephone number for each)
1._____ Telephone_____

2._____ Telephone_____

3._____ Telephone_____
*Children will only be released to a parent or to a person designated by the parent after verification of ID.

_____ *I acknowledge receipt of the facility's operational policies, including those for discipline and guidance.* (Please see the RCBA Handbook on the website www.rcbaonline.com)

_____*I understand that my child will be served an afternoon snack while at After School Care.*

_____*I understand that operating hours for After School Care are Monday-Friday, 3:20-6:00 PM, unless otherwise communicated.*

Authorization For Emergency Medical Attention
_____ *In the event that I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:*
Name of Physician_____ Telephone_____

Address_____City_____State___Zip_____

Name of Emergency Care Facility_____

Address_____Telephone_____

_____ *I have provided River City Believers Academy with a copy of my child's most current immunization record.*

Admission Requirement

One of the following must be presented when your child is admitted the After School Care Program. (*Please check only one option*)

1. _____ HEALTH-CARE PROFESSIONAL'S STATEMENT: *I have examined the above-named child within the past year and find that he/she is able to take part in the After School Care Program.*

   _____

   HEALTH CARE PROFESSIONAL'S SIGNATURE DATE
2. _____A signed and dated copy of a health-care professional's statement is attached.
3. _____Medical diagnosis and treatment conflict with the tenets and practice of a recognized religious organization, which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.
4. _____My child has been examined within the past year by a health care professional and is able to participate in the After School Care Program. Within 12 months of admission, I will obtain a health-care professional's signed statement and will submit it to River City Believers Academy.
   Name of health-care professional_____
   Address_____

List any special problems that your child may have, such as allergies, existing illnesses, previous serious illness, injuries and hospitalizations during the past twelve months, any medication prescribed for long-term continuous use, and any other information which caregivers should be aware of:

_____

_____

_____

_____

Parent Signature_____Date_____/_____/_____

Please, choose your billing rate:

_____Monthly ($225/month)

_____Drop-in ($15/hour)

A one-time fee of $125 will be charged to your FACTS Account upon application.

FOR OFFICE USE ONLY

Application Fee Paid____/____/_____ Date of Admission____/____/_____ Date of Withdrawal____/____/_____