GREENFIELD RECREATION AFTER SCHOOL PROGRAMS

EEC LICENSED DAILY AFTER SCHOOL CARE 2:55PM-5:30PM

OUTDOOR PLAY

ENRICHMENT ACTIVITIES

GYM TIME

DAILY SNACK

FUN

FRIENDSHIP

Programs held at:
Four Corners School
Federal Street School
Service also available for Newton Students at the Federal Street Program

Registration is accepted on a rolling basis as space allows.

Enrollment packets available online or at the Recreation Department.

A minimum enrollment of 2 days per week is required.

2023-2024 TUITION

$15 PER DAY, $1 OFF EACH SIBLING
CARE AVAILABLE ON HALF DAYS:
$30 PER DAY, $2 OFF EACH SIBLING

FOR MORE INFO

Greenfield Recreation Department
20 Sanderson Street, Greenfield, MA 01301
Phone: 413-772-1553 Fax: 413-773-0115
www.greenfieldrecreation.com

Phone: 413-772-1553
Fax: 413-773-0115

2023-2024 Greenfield Recreation After School Program Registration Form

Registration Guidelines

Use one form for multiple class registrations.

Complete this form and be sure to note:

1. **All contact information is complete.**
2. **Include payment for all classes. Checks payable to City of Greenfield Recreation Department.**
3. **Mail to:**
   Greenfield Recreation
   20 Sanderson Street
   Greenfield, MA 01301

OFFICE USE ONLY
Paid _____ Entered _____

ONE PER HOUSEHOLD. PLEASE PRINT CLEARLY.

Parent/Guardian Name _____

Address _____

City/State/Zip _____ Email _____

Home Phone _____ Work Phone _____ Cell Phone _____

Emergency Contact other than yourself. Name _____ Phone _____

Medical Conditions or physical limitations / restrictions _____

LIST EACH PARTICIPANT'S INFORMATION; USE GRADE YOUR CHILD IS IN

Name	Gender	Date of Birth	Grade	Age	Program Name
					Four Corners After School
					Four Corners After School
					Four Corners After School
					Four Corners After School

Please select the days your child(ren) will attend. Minimum of two days required.
Your child will automatically be registered for your selected days for the entire 2023-2024 school year.

☐ **Monday** ☐ **Tuesday** ☐ **Wednesday** ☐ **Thursday** ☐ **Friday**

Release and Waiver Agreement: I the undersigned do hereby consent to my or my child's participation in voluntary athletic or recreation programs of the City of Greenfield Recreation Department. I also agree to forever release the City of Greenfield, the Recreation Commission, and all their employees, agents, board members, volunteers and any and all individuals and organizations assisting or participating in voluntary athletic or recreation programs of the City of Greenfield ("the Releasees") from any and all claims, rights of action and causes of action that may have arisen in the past, or may arise in the future, directly or indirectly, from personal injuries to my child and/or myself or property damage resulting from my child's participation and/or my participation in the City of Greenfield Recreation Department voluntary athletic or recreation programs. Consent: I hereby consent to and authorize Greenfield Recreation Department the right to publish, reproduce and use for advertising or any other purpose, any photograph, video image, an audio recording or other likeness of my child or family member. I further affirm that I have read this Consent and Release Form and that I understand the contents of this Form. I understand that my child's participation and/or my participation in these programs is voluntary and that my child and I are free to choose not to participate in said programs. By signing this Form, I affirm that I have decided to allow my child to participate in the City of Greenfield Recreation Department's athletic or recreation programs with full knowledge that the Releasees will not be liable to anyone for personal injuries and property damage my child or I may suffer in voluntary City athletic or recreation programs.

PRINT NAME OF PARENT OR GUARDIAN _____ DATE _____

SIGNATURE OF PARENT OR GUARDIAN _____

CHILD INFORMATION FORM 2023-2024
GREENFIELD RECREATION AFTER SCHOOL PROGRAM AT FOUR CORNERS SCHOOL

CHILD INFORMATION

Name: _____ DOB:_____ Age: _____ Gender:_____

School: _____ Grade: _____ Teacher: _____

Eye Color: _____ Hair Color: _____ Weight: _____ Height: _____

Identifying Marks:_____

Please list any medical needs, dietary restrictions, allergies, etc. _____

_____

Please attach a current photograph of your child.

Does your child carry an Emergency Medication (EpiPen® or inhaler)? Yes_____ No_____
*PLEASE NOTE: If your child carries an EpiPen® or inhaler, one must be supplied to GRASP

Child's Physician: _____ Phone: _____

Child's Dentist: _____ Phone: _____

Hospital Preferred: _____ Health Insurance Carrier & Policy #: _____

Does your child have a chronic health condition? YES ☐ NO ☐ If yes, an individual health plan must be completed.

Are there any custody agreements, court orders, or restraining orders that pertain to the child? YES ☐ NO ☐ If yes, please attach

PARENT/GUARDIAN INFORMATION

Name: _____ Relationship to Child: _____

Address: _____ Town: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Best # to Reach: _____ Email Address: _____

Name: _____ Relationship to Child: _____

Address: _____ Town: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Best # to Reach: _____ Email Address: _____

ADDITIONAL PICK-UP CONSENT

In the event that I cannot pick up my child for any reason, I authorize GRASP to release my child to the following individuals:

Name: _____ Relationship to Child: _____ Phone: _____

Name: _____ Relationship to Child: _____ Phone: _____

Name: _____ Relationship to Child: _____ Phone: _____

EMERGENCY CONTACTS

If Parent(s)/Guardian(s) cannot be reached.

Name: _____ Relationship to Child: _____ Phone: _____

Name: _____ Relationship to Child: _____ Phone: _____

Name: _____ Relationship to Child: _____ Phone: _____

PLEASE COMPLETE BOTH SIDES

CONSENT

I authorize GRASP staff to give my child first aid when appropriate. If my child requires further medical attention, 911 will be called and I will be notified immediately. I understand if I cannot be reached, an emergency contact will be notified. If my child needs to be taken to the nearest medical care facility or to my preferred hospital listed above by ambulance, one staff person will accompany my child. I also give permission to the attending physician to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child as indicated. I will accept responsibility for any expenses incurred in handling this emergency care.

Parent/Guardian (Print): _____ Signature:_____ Date: _____

HEALTH HISTORY AND IMMUNIZATION RECORDS

I attest that my child's health and immunization records are on file with the Greenfield Public Schools.

Parent/Guardian (Print): _____ Signature:_____ Date: _____

RELEASE OF INFORMATION

For the purpose of continuity of care, I hereby give permission for Greenfield Public Schools and GRASP to release information to each other in regards to my child. Information may be shared in written or verbal format.

Parent/Guardian (Print): _____ Signature:_____ Date: _____

PERMISSION TO APPLY HAND SANITIZER

I give my child permission to use hand sanitizer containing at least 60% alcohol to prevent the spread of COVID-19.

I do_____ I do NOT_____ give permission for my child to use hand sanitizer. INITIALED: _____

COVID-19 TESTING RELEASE

I give permission for my child to be administered a COVID-19 Rapid Antigen Test if they become symptomatic at the program.

I do_____ I do NOT_____ give permission for my child to be tested. INITIALED: _____

PUBLICITY/PHOTO RELEASE

I understand that my child may be photographed or videotaped by the Greenfield Recreation Department for use on website, in promotional/ publication materials, and for grant purposes. Newspaper and television staff may also photograph or videotape my child should they feature the program.

I do_____ I do NOT_____ give permission for my child to be photographed/videotaped. INITIALED: _____

PARENT HANDBOOK ACKNOWLEDGEMENT

I have read and understand all of the policies in the Greenfield Recreation After School Program (GRASP) at Four Corners School as stated in this handbook. I agree to follow the handbook policies accordingly. I do understand that all policies listed in this handbook will be enforced, and failure to comply with the policies, is reason for immediate termination.

Parent/Guardian (Print): _____ Signature:_____ Date: _____

ANYTHING ELSE WE SHOULD KNOW?

_____

_____

_____

_____

_____

Please return this form to the Greenfield Recreation Department, 20 Sanderson Street, Greenfield, MA 01301
Phone: (413)772-1553 Fax: (413)773-0115 Website: www.greenfieldrecreation.com

This form must be completed and submitted before your child begins the program. It will be placed in their file for reference.

FOR OFFICE USE ONLY:

DATE OF ADMISSION: _____ REVIEWED BY:_____

GRASP at Four Corners School

Transportation Plan and Authorization

CHILD'S NAME:_____

MY CHILD WILL ARRIVE AT THE PROGRAM:

___ESCORTED BY SCHOOL PERSONNEL

MY CHILD WILL DEPART FROM THE PROGRAM:

___PARENT/GUARDIAN OR AUTHORIZED PICK UP

PARENT /GUARDIAN SIGNATURE_____ DATE_____

Greenfield Recreation After School Program
Payment Plan Authorization Form

PLEASE PRINT LEGIBLY

Child's Name: _____

GRASP Site: **Federal Street** **Four Corners**

Cardholder's Name: _____
FIRST MIDDLE INITIAL LAST

Email: _____ **Phone:** (_____)_____

☐**Discover** ☐**Mastercard** ☐**Visa**

Card Number: _____ **Expiration:** _____/_____ **CVV Code:**_____

Billing Address:_____
STREET CITY STATE ZIP

Monthly Payment Date: **1st (or next business day)** **Start Date:** ____/_____/_____

Payments are processed in advance. For example, February Tuition is paid on February 1st.

Pay Monthly Tuition

- Monthly tuition is based upon number of days enrolled

Would you like a receipt of each month's payment? ☐No Receipt ☐Emailed ☐Printed

I authorize the Greenfield Recreation Department (service provider) to charge my credit/debit card as identified above to the terms stated here. This authorization shall remain in effect until the service provider receives written notification from me of intent to terminate at such time and in such a manner as to afford the service provider reasonable opportunity to act (minimum of 30 days).

I understand my payment will be processed on the 1st of every month, or the next business day. I further understand that payment amount will vary from month to month based on the number of days my child is enrolled in the program.

I represent and warrant that I am authorized to execute this payment authorization for the purpose of implementing this payment plan. I indemnify and hold the service provider, the bank, and the merchant harmless for damage, loss or claim resulting from all authorized actions hereunder.

_____ _____
Customer Signature Date

The Commonwealth of Massachusetts
Department of Early Education and Care

POLICY	
Individualized Health Care Plans	**Applicability: All Licensed and Funded Child Care Programs**
Effective Date: October 29, 2010 **Updated: June 30, 2022**	

BACKGROUND

Comprehensive, individualized child care begins with planning and preparation, especially for children with chronic health care needs. It is critical for programs to have a plan that clearly describes what needs to be done, when, and by whom to respond to the child's actual and potential health care needs. Good planning is informed by the child's parents and health care provider, and often includes training and consultation for program staff.

POLICY STATEMENT

The licensee must maintain as part of a child's record, an up-to-date individualized health care plan for care for each child with a chronic medical condition which has been diagnosed by a licensed health care practitioner. This plan is used to outline the child's medical needs and how they should be handled by the program.

An individualized health care plan must include the following:

- The child's name, age, and assigned classroom, if applicable.
- A description of the child's medical condition and its symptoms.
- Instructions for any medical treatment that may be necessary while the child is in care, including the name of the staff person who will be administering the child's treatment while the child attends the program, and identification of any potential side effects of the treatment.
    - Program administrators should use the child's individualized health care plan to identify what specific training and supervision must be available for educators administering the child's treatment plan.
- Explanation of the potential consequences to the child's health if the treatment is not administered.
- Name and contact information of the child's licensed health care practitioner

A program may provide the EEC Individual Health Care Plan form (attached below) to the family to have their child's physician complete or a program may accept equivalent physician's forms (i.e. asthma action plans, diabetes action plans, IEP *with* medical content) as long as those forms contain the same information that would be provided on the EEC form.

A current copy of the individualized health care plan must be maintained in the child's file. It is recommended that a copy of the plan also be in the child's classroom, on field trips, and with the child outdoors, along with any rescue medication, if applicable.

There must be one person trained in the implementation of a child's individualized health care plan whenever the child is in the care of the program[1].

Individualized health care plans must be kept confidential and should be shared only with those program staff who might need to deal with an emergency involving the child.

Individualized health care plans shall be valid for one year, unless withdrawn sooner, and must be renewed annually and following any change to the child's condition for administration of medication and/or treatment to continue.

Please note: Programs must maintain current copies of all required parental consents for medication administration and emergency medical treatment, as required by 606 CMR 7.04(7)(a)4 and 606 CMR 7.11(1) and (2). See also Compliance Requirements for Center-Based Funded Programs 8.13(2)(a)4 and 8.03(3)(b-c). Copies of any applicable written consent forms from the child's parent(s) must be stored with the child's individualized health care plan.

EEC *strongly* recommends that, upon enrollment and re-enrollment, the program talks to parents about their child's individual health care needs.

When is an individualized health care plan required?

A licensee must have an individualized health care plan for any child who has been diagnosed with a chronic medical condition, including but not limited to a condition that may require an emergency response or ongoing, long-term administration of health care procedures. Examples of common conditions that require an individualized health care plan include, but are not limited to:

- asthma
- epilepsy
- diabetes
- serious allergies
- anaphylaxis
- physical disabilities
- ADD/ADHD

For additional guidance and resources, please visit https://www.mass.gov/lists/health-and-safety-in-childcare-resources-for-child-care-health-consultants

AUTHORITY

606 CMR 7.11(3)(a)(c): *Individual Health Care Plans. The licensee must maintain as part of a child's record, an individual health care plan for each child with a chronic medical condition, which has been diagnosed by a licensed health care practitioner. The plan must describe the chronic condition, its symptoms, any medical treatment that may be necessary while the child is in care, the potential side effects of that treatment, and the potential consequences to the child's health if the treatment is not administered.*

See also ***Compliance Requirements for Center-Based Funded Programs 8.13(2)(a)8(d).***

[1] All staff who administer medication of any kind must be trained in medication administration, as required by 7.11(1)(b)2.

EEC Individual Health Care Plan Form

Name of child:	Date of Birth:
Name of chronic health care condition:	
Description of chronic health care condition:	
Symptoms:	
Medical treatment necessary while at the program:	
Who has been trained and will be administering this treatment while the child is at the program:	
Potential side effects of treatment:	
Potential consequences if treatment is not administered:	
(Optional) Other recommendations (e.g., further tests, treatments, mitigating measures, accommodations required to allow for the child's full participation, etc.)	

Name and Phone Number of Licensed Health Care Practitioner (please print):_____

Parental/Guardian Signature: _____Date:_____

Program Administrator Signature: _____ Date:_____

For Older Children ONLY (9+ years of age)

In accordance with 606 CMR 7.11(3)(b-c) and with written parental consent and authorization of a licensed health care practitioner, this Individual Health Care Plan permits older school age children to carry their own inhaler and/or epinephrine auto-injector and 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 Care Plan specifying how the inhaler or epinephrine auto-injector will be kept secure from access by 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 on-site a back-up supply of the medication for use as needed.

Age of child: _____ Date of birth: _____ Back-up medication received? YES NO

Parent's Signature: _____ Date: _____

Program Administrator's Signature: _____Date: _____

Commonwealth of Massachusetts
Department of Early Education and Care

MEDICATION CONSENT FORM 606 CMR 7.11(2)(b)

Name of child: _____

Name of medication: _____

Please ✓ one of the following: Prescription: _____ Oral/Non-Prescription: _____

Unanticipated Non-Prescription for mild symptoms_____

Topical Non-Prescription (**applied to open wound/ broken skin)**_____

My child has previously taken this medication_____

My child has **no**t previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan_____

Dosage: _____

Date(s) medication to be given: _____

Times medication to be given: _____

Reasons for medication: _____

Possible side effects: _____

Directions for storage: _____

Name and phone number of the prescribing health care practitioner:

_____

Child's Health Care Practitioner Signature _____**Date**_____

I, _____**, (parent or guardian) gives permission**
(print name)

to authorize educator(s) to administer medication to my child as indicated above.

Parent/Guardian Signature _____ **Date**_____
For topical, non-prescription **NOT** applied to open wound / broken skin (**parent signature only)**