



Financial Agreement 2022

School Age Summer Camp

Child's Name: _____

Grade recently completed: _____

Set Schedule:

How many days per week?

Mark which days:

Monday:

Tuesday:

Wednesday:

Thursday:

Friday:

Tuition Plan Rates: (circle selected plans)

Weekly Tuition
7am-5pm

5 days	4 days	3 days
\$230.00	\$198.00	\$151.00

Field trip costs are included in weekly tuition for 3, 4, and 5 day plans

Extended Care

\$5 arrival between 6:30-7:00 am	\$10 arrival between 6-6:30am	daily, per child
\$5 pick-up between 5-5:30 pm	\$10 pick-up between 5:30-6:00 pm	

Important Policies:

See our Parent Handbook for a complete listing of all of our policies and procedures. Listed below are several for you to review. Please initial that you've read and understood each section.

Enrolling and Withdrawing:

- A non-refundable registration fee of \$50 per student is due with enrollment. PHCA school age students are required to pay one registration fee per calendar year.
- A non-refundable deposit equivalent to two week's tuition is due at the time of registration. This deposit will be applied to your child's first and last weeks of camp.
- A two week notice must be given when withdrawing your child from the program.

Parent Initial - I have read and understood.

Additional Fees & Discounts:

- After 6:00 p.m., a late fee of \$1.00 per minute per child will be charged and invoiced separately.
- Extended Care charges will accrue with drop-off or pick-up times outside of 7am - 5pm, \$5 per half hour, as outlined above
- Field trip fees are included in 3, 4, and 5 day a week plans.
- Students with less than 3 day tuition plans will be charged an additional fee if they attend on a field trip day.
- Vacation: Participants enrolled in a 3- or more days per week tuition plan on a consistent schedule for the entire duration of the summer program will receive one week's worth of vacation credit applied to the last week of camp (8/22-26 week) if they take a full week of vacation during the summer AND provide notice to the teacher and Accounts Manager 2 weeks prior. See Parent Handbook for other specifics regarding our Vacation Policy.

Parent Initial - I have read and understood.

Billing Details:

- A \$35 charge will be added to your account in the event of insufficient funds.
- A 3% merchant fee is charged on credit/debit forms of payment
- A 5% late fee applies to overdue balances
- The tuition remains the same whether your child is in attendance or not. No credits will be given for holidays, days your child is absent due to illness or for the center closing due to illness or weather.

Parent Initial - I have read and understood.

Other:

I am aware that Kids Kare Center in a ministry of the Harbor Church; the Harbor is a safe place of protection and provision where people can seek wholeness, balance and destiny for life's journey through Jesus Christ. I have read the Harbor's Affirmation of Faith (in the Parent Handbook) and I am aware that Kids Kare Center will uphold those truths to my child.

Parent Initial - I have read and understood.

Payment Selection & Agreement:

Initial to agree to your payment option

select and initial only one

I choose the Auto-Pay Weekly Payment Option for Tuition which is \$_____.

I choose the Manual Weekly Payment Option for Tuition which is \$_____. I will pay on Friday and know a late fee of 5% will be added if I do not.

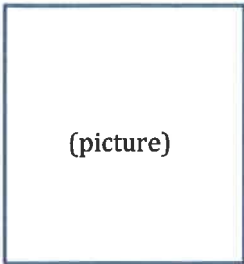
Signature: _____

Today's Date: _____

Email address to send invoices: _____

Start or Change Date: _____

Kids Kare Center Emergency Information



Child's Name _____ Birthdate _____

Mother's Name _____

Address _____ Zip _____

Mother's Employer _____ Phone _____ Hours _____

Email Address _____ Cell Phone # _____

Father's Name _____ Address (if different than above) _____

Father's Employer _____ Phone _____ Hours _____

Email Address _____ Cell Phone # _____

In case of an emergency and parents cannot be reached, call:

Name _____ Phone _____ Relation _____

Address _____

Name _____ Phone _____ Relation _____

Address _____

Doctor _____ Clinic _____ Phone# _____

Dentist _____ Clinic _____ Phone# _____

Preferred Emergency Room _____

Names of authorized drop-off/pick-up people _____

List anyone **not** authorized up the child _____

Dietary Needs - please list: _____

Known Allergies _____

Medical Problems _____

I hereby give my permission to the staff of Kids Kare Center to secure medical help, including the services to the rescue squad of the emergency room, in the event of an emergency.

Signature _____ Date _____



General Release, Field Trip & Sunscreen

Consent Form 2022

General Release:

In consideration of the permission granted by _____ (Parent/Guardian) for _____ (Student's name) to attend the Summer Day Camp Program and all field trips, taken from the premises, I hereby release and discharge Kids Kare Center, PHCA, The Harbor Church, its agents, volunteers, employees, and officers from all claims, demands, actions, judgements, and executions which the undersigned's heirs, executors, administrators and assigns may have or claim to have against its successors or assigns to all personal injuries known or unknown, and injuries to property caused by or arising out of the above described attendance and activities.

Field Trips:

I have received a tentative calendar of events and understand that if any of these events change, I will be notified of the change (may be over email or text if it is a same-day change).

I understand that Kids Kare Center's summer program will take every precaution to ensure the well-being and safety of my child. A staff of adults will be accompanying my child on field trips and will provide proper supervision, exercising every precaution to avoid accidents, in accordance with the state licensing regulations. Hastings Bus Company will provide transportation to and from off-site activities.

I hereby give my consent for _____ (Student Name) to attend summer events and be transported by a Kids Kare Center staff member on a school bus.

Sunscreen/Hand Sanitizer:

I give permission to KKC staff to apply sunscreen (SPF 30 or higher) to my child before playing outdoors. I understand that they will be using store bought sunscreen. If I want a special sunscreen applied other than the one provided by KKC, I understand I need to supply it and complete a separate form. I give my permission for staff to provide my child hand sanitizer when proper handwashing is not available.

Parent Signature _____ Date _____



2022 Swim Form

My child _____ 's swim level is

Do they: (check all that apply)

	Wear a life vest/arm floaties (✓ frequency needed) Always /or/ Just when chest deep
	Wear a UV swim shirt
	Can swim in deep end by themselves

Anything else staff should know? _____

Water-day Rules:

We have safety protocols and training which all of our Summer Camp Teachers had completed. All KKC staff members (including summer help) are CPR/1st Aid Trained and Certified by the American Red Cross.

- Students are not allowed to go into the water past chest depth if they cannot swim or without floaties/life jackets.
- Teacher(s) is/are always in the water at the deepest allowed water depth, making sure no child/ren are swimming past the safety zone.
- We encourage students who are not comfortable swimmers to bring floaties/life jackets. Some water parks may conduct swim tests and may provide floaties/life jackets. Students who need assistance swimming are required to wear safety devices before entering the water.
- Sometimes students will also be split into smaller groups, by age or by ability level, to help teachers focus on a specific number of kids rather than the entire class at once.
- Activities are always planned in group settings.
- No child is allowed to enter the water alone without a staff member present.
- We take breaks every 30 minutes where everyone is required to exit the water, at which point students are welcome to play on the beach or rest. A staff member is always positioned between the water and the students, ensuring no child/ren is/are entering the water unattended.

Not required for PHCA Students

Health Care Summary

MUST BE COMPLETED BY A HEALTH CARE SOURCE

Name of Child:	Enrollment Date: ___/___/___
Address:	Birth Date: ___/___/___
Parent/Guardian:	Telephone: _____

Date of last physical exam: ___/___/___

Height: _____ Weight: _____ Blood Pressure: _____

Is the child up-to-date on their immunizations? Yes No

If no, plan for bringing the child up-to-date: _____

What is the status of the child's:

Please specify any conditions that would restrict this child's activities in:

Vision: _____

Classroom activity: _____

Hearing: _____

Physical education: _____

Speech: _____

Competitive sports: _____

Please list any medications the child is on: _____

Is a modified diet necessary? _____

Does this child have any allergies, including allergies to medications? _____

Does the child have any conditions that may result in an emergency? _____

Is there any other information that would be helpful in a childcare or school setting? _____

<u>List any Important Health Problems</u>	<u>Followed By You</u>	<u>Followed by Other Health Care Source</u>	<u>List any Accommodations Required by the Program</u>
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Primary health care provider's name: _____

Clinic Name: _____ Telephone: _____

Address: _____
Street City State Zip

Signature of Health Care Provider: _____ Date: _____

Immunization Form

Name _____

Birthdate _____

Enter the dates for each vaccine your child has received to date. Specify the month, day, and year of each dose such as 01/01/2010.

Immunizations required for child care, early childhood programs, and school.

Vaccine	Birth to 6 months	12 -24 months	At Kindergarten	At 7th grade	At 12th grade
Hepatitis B	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>Haemophilus influenzae</i> type b (Hib)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Pneumococcal (PCV)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Polio	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Measles, Mumps, Rubella (MMR)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Chickenpox (varicella)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hepatitis A	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Tetanus, Diphtheria, Pertussis (Tdap)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Meningococcal (MCV4)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Minnesota law requires children enrolled in child care, early childhood education, or school to be immunized against certain diseases, unless the child is medically or non-medically exempt.

Instructions for parent or guardian:

- Fill out the dates in chronological order even if your child received a vaccine outside of the age/grade category that the box is in. Depending on the age of your child, they may not have received all vaccines; some boxes will be blank.
- If you have a copy of your child's immunization history, you can attach a copy of it instead of completing the front of this form.
- Your doctor or clinic can provide a copy of your child's immunization history. If you are missing or need information about your child's immunization history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-3980 or 800-657-3970.
- Sign or get the signatures needed for the back of this form.
- Document medical and/or non-medical exemptions in section 1.
- Verify history of chickenpox (varicella) disease in section 2.
- Provide consent to share immunization information (optional) in section 3.

Instructions: Complete section 1 to document a medical or non-medical exemption, section 2 to verify history of varicella disease, and section 3 to consent to share immunization information.

Name _____

1. Document a medical and/or non-medical exemption (A and/or B).

Place an X in the box to indicate a medical or non-medical exemption. If there are exemptions to more than one vaccine, mark each vaccine with an X.

Vaccine	Medical Exemption	Non-Medical Exemption
Diphtheria, Tetanus, and Pertussis		
Polio		
Measles, Mumps, Rubella		
<i>Haemophilus influenzae</i> type b		
Chickenpox (varicella)		
Pneumococcal		
Hepatitis A		
Hepatitis B		
Meningococcal		

B. Non-medical exemption: A child is not required to have an immunization that is against their parent or guardian's beliefs. However, choosing not to vaccinate may put the health or life of your child or others they come in contact with at risk. Unvaccinated children who are exposed to a vaccine-preventable disease may be required to stay home from child care, school, and other activities in order to protect them and others.

By my signature, I confirm that this child will not receive the vaccines marked with an X in the table because of my beliefs. I am aware that my child may be required to stay home from child care, school, and other activities if exposed.

Signature: _____ Date: _____
(of parent or guardian in presence of notary)

Non-medical exemptions must also be signed and stamped by a notary:

This document was acknowledged before me

on _____ (date)

by _____
(name of parent or guardian)

Notary Stamp



Notary Signature: _____

STATE OF MINNESOTA, COUNTY OF _____

Signature: _____ Date: _____
(of health care practitioner*)

2. History of chickenpox (varicella) disease. This child had chickenpox in the month and year _____

My signature below means that I confirm that this child does not need chickenpox vaccine because:

- I am a health care practitioner and this child was previously diagnosed with chickenpox or the parent provided a description that indicates this child had chickenpox in the past.
- I am the parent or guardian and this child had chickenpox on or before September 1, 2010.

Signature: _____ Date: _____
(of health care practitioner*, representative of a public clinic, or parent/guardian). Parent can sign if chickenpox occurred before September 2010.

*Health care practitioner is defined as a licensed physician, nurse practitioner, or physician assistant.
Minnesota Department of Health - Immunization Program (2019)

- 3. Consent to share immunization information:** This school is asking for permission to share your child's immunization record with Minnesota's immunization information system. Giving your permission will:
 - Provide easier access for you and your school to check immunization records, such as at school entry each year.
 - Support your school in helping to protect students by knowing who may be vulnerable to disease based on their immunization record. This can be important during a disease outbreak.
 - Under Minnesota law, all the information you provide is private and can only be released to those authorized to receive it. Signing this section of the form is optional. If you choose not to sign, it will not affect the health or educational services your child receives.
 - I agree to allow my child's school to share my child's immunization documentation with Minnesota's immunization information system:
- Signature: _____ Date: _____
(of parent/guardian)

Only complete if you want to bring your own sunscreen, soap, lotion, etc. from home.

Non-Prescription Medication Products Authorization Only

FORM M-400

All over-the-counter (OTC) products need parental permission for administration. However, some of these external products do not need to be documented every time you use them. The following is a list requiring parental permission only.

TO BE COMPLETED BY PARENT

Child's Name: _____ Date of Birth: ____/____/____
Program Name: _____ Today's Date: ____/____/____

The following external products may be applied to my child in accordance with the manufacturers instructions on the original container:

- _____ Diaper wipes
- _____ Diaper creams, ointments
- _____ Skin lotions/creams/vaseline: specify if special brand: _____
- _____ Baby oil; (baby powder is not recommended due to inhalation hazards)
- _____ Soap, Brand Name: _____
- _____ Sunscreen: specify if special brand: _____
- _____ Insect repellants: specify if special brand: _____
- _____ Lip balm
- _____ Chemical hand sanitizers
- _____ Toothpaste (an internal product but does fall under this category)
- _____ Other - please specify: _____

NOTE: Teething gels are considered OTC medications not products (use **Form M-200**) Teething gels are not recommended and need to be used with extreme caution. They have been known to numb the throat which causes a potential choking hazard.

Parents/Guardian's signature required: _____

* Unused products: Returned to parents? Yes / No or, discarded appropriately (circle one)

by: _____ Date: ____/____/____

***Keep this form in the child's file when medication is finished.**

All oral OTC medications need Prescription (Form M-200) or Non-Prescription (Form M-300) Medication Authorization/Administration Form completed.