

**City of Gulfport Recreation Division, 5730 Shore Blvd. S., Gulfport, Florida  
2011-2012 School Year Child Care Program**

**READ/SIGN THIS PAGE BEFORE CONTINUING...**

**PAYMENT RESPONSIBILITY**

The parent/legal guardian signing these registration papers will be responsible for all payments. Financial assistance programs will NOT be held responsible. Late payment for the amount of **\$10 (per family)** will be collected **after the fifth** of each month. Child/children will be unable to attend Recreation if payment has not been made by the 10<sup>th</sup> of each month.

**COORDINATED CHILD CARE PARENTS ONLY**

CCC payments are due on **Friday** prior to each week. A **\$10** late fee is applied – **per family – per week** - if payment is not received by Monday morning. If payment is not received by Friday of the week, the child will be unable to return to Recreation. Parents are responsible for paying the program daily rate fee IF the child is over their allotted absences with no documentation provided (even if the child is suspended) and if the child is not signed in or out on the attendance rosters (CCC considers this an absence).

**PROOF OF RESIDENCY**

All persons registering their child/children MUST provide a Florida Diver's License or Florida Identification Card W/ CURRENT GULFPORT ADDRESS and...

- \* two current utility bills w/current Gulfport address – water, gas, electric, phone, cable (OR)
- \* two current personal bills w/ Gulfport address – automobile registration, voters information card, credit card bill, medical or bank statement (OR)
- \* Declaration of Domicile w/ any two items listed above

**GUARDIANSHIPS**

All legal guardians MUST provide temporary/permanent custody, adoption papers, Power of Attorney or a notarized written statement for Guardianship for their child/children to register using Gulfport resident rates.

**REFUND POLICY**

Annual Registration Fee of \$15 resident / \$100 non-resident is non-refundable. A full program fee refund will be made only if the request for a refund is made **PRIOR to the FIRST DAY of ANY PROGRAM\*** (the only exceptions would be if a child could not attend due to a documented medical reason). Partial or pro-rated refunds will not be made.

**FIELD TRIP PERMISSION**

I understand that the Gulfport Recreation Division will be offering field trips throughout the program and that I will be given at least a 2-day notice of field trip information.

**PERMISSION TO PARTICIPATE**

I/We accept full responsibility for the above named child, my/our son/daughter, and by signing below give my/our permission for him/her to participate in the recreation program as offered by the Gulfport Recreation Division. I/We understand the nature of the program, its activities, the arrangements regarding the time of meeting, and fees. I/We also understand that my child will receive a nutritious snack everyday and it is my responsibility to notify the center of my child's food allergies. I/We also understand that the nature of this recreation program does not allow my/our son/daughter to enter or leave the premises of the Recreation Center at which they are registered without permission of the Recreation staff and a signed note from his/her parents or legal guardian.

**HOLD HARMLESS AND WAIVER FOR MINOR**

As the parent or guardian of a minor child participating in activities or using any facilities of the City of Gulfport, Florida, I hereby waive, on behalf of said child, for myself and my spouse, if any, any claim against the City of Gulfport and its servants and employees, hereafter arising from injuries to the child identified on this form, which said injury is sustained while upon said facilities, participating in said activities or being transported therefrom or thereto, regardless of whether such injury is caused in whole or in part by the negligence of said city or by the negligence of the agents, servants and employees thereof, and I do hereby covenant to indemnify, hold harmless and defend the said City, its agents, servants and employees from any claim, damages or demand hereafter arising against the City or their agents, servants or employees of the City, arising out of the child's use of the facilities, participation in the activities, or being transported therefrom or thereto.

I hereby give my permission for the City of Gulfport to call my physician and/or to arrange for transportation to a hospital in the event of any injury to said child, and to administer first-aid as deemed necessary by the City, although I understand that the City assumes no responsibility to do so. I hereby waive any claim against the City of Gulfport, its agents, servants or employees arising from any administration of first-aid; by any of the foregoing or arising from any act or omission thereby in responding to any injury to the said child.

**PERMISSION OF PRESS RELEASE**

I understand that the City of Gulfport may take photographs or video of my child during the School Year Child Care Program activities. I understand that the City may release my child's name along with his/her picture for publication in the newspaper, program brochures or fliers. I also understand that the City of Gulfport may use video footage of my child for the School Year Child Care Program for public relations presentations.

**PARENT/PROVIDER AGREEMENT**

Listed are additional fees or charges not covered by Coordinated Child Care, Inc., or parent monthly fees: Annual Registration Fee - due at initial registration, \$15 resident / \$100 non-resident. Possible activity fees: Treasure Island Fun Center - \$9.00, Astro Skate (roller skating) - \$6.00, Bowling-\$6.00, Chuck-E-Cheese-\$7.00. Miscellaneous activities/field trips to be announced. The amounts listed will not exceed the amount listed.

**The information I have provided in this packet is accurate to the best of my knowledge and I have agreed to arrangements for paying fees. I also have received and understand the policies stated in the parent handbook. Falsifying information may result in program dismissal for my child/children with NO REFUND.**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Date

Child's Legal Name: \_\_\_\_\_  
(FIRST) (M.I.) (LAST)

## DISCIPLINARY PRACTICES

The following is a list of disciplinary practices to be followed by the Center in event of incidents. It is important that your child understand the procedures that will be taken. Please share the following information with your child. Signatures are required below.

1. First offense: Written warning, dated & recorded
2. Second offense: Written warning, dated & recorded
3. Third offense: Written warning, child meets with Director, Parent conference
4. Fourth offense: One (1) day suspension from the program
5. Fifth offense: Three (3) day suspension from the program

Immediate or next-day suspension may be used following:

- a. Fighting
- b. Physical or verbal abuse of staff or children
- c. Stealing
- d. Destruction of property
- e. Destruction or throwing of food and drink
- f. Spitting on or in the direction of others

Any further violation of the Discipline Guidelines (see parent's handbook) will result in termination from the program.

Parent/Guardian's Signature \_\_\_\_\_

Child's Signature \_\_\_\_\_

Date \_\_\_\_\_



# CHILD'S ENROLLMENT RECORD

**DIRECTOR'S USE ONLY**

Date enrolled \_\_\_\_\_

Child's full legal name \_\_\_\_\_  
First Middle Last

Sex \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Child's preferred name/nickname \_\_\_\_\_

Address \_\_\_\_\_  
Street Address (number, apartment#, street) City State Zip

Primary Hours (circle one): 2:30 – 5:30 p.m. or 2:30 p.m. – 6 p.m. Program is 5 days a week Mon. – Fri.

Special Departure Instructions \_\_\_\_\_

Who has legal custody \_\_\_\_\_ Relationship \_\_\_\_\_

Custodial Parent or Legal Guardian \_\_\_\_\_ Email \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Home Address \_\_\_\_\_  
Street Address (number, apartment#, street) City State Zip

Place of employment \_\_\_\_\_ Telephone ( ) \_\_\_\_\_

Address of employer \_\_\_\_\_  
Street Address (number, apartment#, street) City State Zip

Custodial Parent or Legal Guardian \_\_\_\_\_ Email \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Home Address \_\_\_\_\_  
Street Address (number, apartment#, street) City State Zip

Place of employment \_\_\_\_\_ Telephone ( ) \_\_\_\_\_

Address of employer \_\_\_\_\_  
Street Address (number, apartment#, street) City State Zip

The child will be released only to the person(s) authorized, or in the manner authorized, in writing, by the custodial parent(s) or legal guardian(s). The following person must be someone **other than** the custodial parent(s) or legal guardian(s) and is authorized to remove the child from the facility in case of illness, accident, or emergency, if for some reason the custodial parent(s) or legal guardian(s) cannot be reached:

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_  
Street Address (number, apartment#, street) City State Zip

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_  
Street Address (number, apartment#, street) City State Zip

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

# CHILD'S ENROLLMENT RECORD

Child's physician/health resource \_\_\_\_\_

Telephone Number (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_  
Street Address (number, apartment #, street) City State Zip Code

Hospital preference \_\_\_\_\_

Name of Dentist \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_  
Street Address (number, apartment #, street) City State Zip Code

## MISCELLANEOUS INFORMATION

List all known allergies \_\_\_\_\_  
\_\_\_\_\_

List all identifying scars, birthmarks, skin discolorations \_\_\_\_\_

Special medical or dietary needs of child \_\_\_\_\_  
\_\_\_\_\_

List any areas of concern \_\_\_\_\_  
\_\_\_\_\_

My signature below verifies that:

I give permission to consult the child's physician/health resource listed above in case of emergency if parent/guardian cannot be reached.

I have received a copy of the "Know Your Child's Children's Center" brochure, and a copy of the children's center discipline policy.

I was notified that the snacks/meals served daily are: Breakfast  AM Snack  Lunch  PM Snack  Dinner

I verify that the information on this enrollment form is complete and accurate.

\_\_\_\_\_  
Signature of Custodial Parent or Legal Guardian

\_\_\_\_\_  
Date



EMERGENCY MEDICAL RELEASE

Please Print Information

Child's Full Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Allergies: \_\_\_\_\_ Medicines Routinely Taken: \_\_\_\_\_

Name of Custodial Parent(s)/Legal Guardian(s): \_\_\_\_\_

Address: \_\_\_\_\_  
*Street Address (number, apartment #, street) City, State, Zip Code*

Home Telephone (\_\_\_\_) \_\_\_\_\_ Cell Telephone(\_\_\_\_) \_\_\_\_\_ Work Telephone (\_\_\_\_) \_\_\_\_\_

Home Telephone (\_\_\_\_) \_\_\_\_\_ Cell Telephone(\_\_\_\_) \_\_\_\_\_ Work Telephone (\_\_\_\_) \_\_\_\_\_

Family Physician's Name/Health Care Resource: \_\_\_\_\_

Address: \_\_\_\_\_  
*Street Address (number, apartment #, street) City, State, Zip Code*

Telephone (\_\_\_\_) \_\_\_\_\_

Dentist Name: \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_  
*Street address (number, apartment #, street) City, State, Zip Code*

Hospital Preference: \_\_\_\_\_  
*Name City*

Medical Insurance Company: \_\_\_\_\_

Policy #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Emergency Contact (other than parent/guardian): \_\_\_\_\_

Address: \_\_\_\_\_  
*Street Address (number, apartment #, street) City, State, Zip Code*

Home Telephone (\_\_\_\_) \_\_\_\_\_ Work Telephone (\_\_\_\_) \_\_\_\_\_

Please sign in the presence of the Notary.

I hereby give my consent to any emergency facility and physician to administer necessary treatment to my child \_\_\_\_\_, in the event of an emergency at which time I cannot not be reached. I give consent to transport by ambulance if situation warrants it.  
*(Child's Full Name)*

Signature of Custodial Parent/Legal Guardian (Affiant)

STATE OF FLORIDA COUNTY OF \_\_\_\_\_

The foregoing instrument was acknowledged before me this \_\_\_\_\_ 20\_\_\_\_\_  
*(Month) (Day) (Year)*

by \_\_\_\_\_, who is personally known to me or who has  
*(Name of Affiant)*

SEAL OF NOTARY

produced \_\_\_\_\_ as identification.  
*(Type of identification)*

Signed: \_\_\_\_\_  
*Signature of Notary*