FAMILY NAME: ___________________________

SHIMEK BASP ENROLLMENT AGREEMENT

I, _________________, understand that I am enrolling my child: ___________________ for the upcoming school year. (2023-2024)

__________ Afternoons only (after school until 5:30 p.m.) -- Fee: $240/monthly

__________ Mornings Only -- Fee: $100/monthly

__________ Full time afternoons & Mornings (after school until 5:30 p.m.) -- Fee: $270/monthly

- ☐ I want to pay monthly
- ☐ I have CCA

I understand that I have an enrollment fee of $75.00 for the first child and $50.00 per child for any other children I am enrolling. This enrollment fee is due before my child can start at the program.

I understand that I must give a thirty day notice before leaving the program.

I understand that the program is open according to the official school calendar of the Iowa City Community School District and is closed during vacation and inclement weather days.

I understand and agree to these terms.

______________________________________ ____________

Signature of Parent/Guardian Date

Tuition Agreement

I understand I am responsible for paying tuition prior to the first of every month. I am aware the penalty is $10 per day for paying tuition after the 1st of the month. If tuition is not paid by the 8th of the month, the child will be suspended until all fees and tuition is paid in full. If tuition and fees are not paid by the end of the calendar month, the child will be discharged from the program.

______________________________________ ____________

Signature of Parent/Guardian Date

Shimek BASP Child Registration

Child's First Name	Last Name	Date of Birth	Sex

Address	City, State, Zip

Parent/Guardian	Home Phone ( )	Cell Phone ( )
Workplace	Work Phone ( )	Cell Phone Provider
Address, City, State, Zip (if different from child)	Email	

Cell provider allows us to send text alerts in the event of an emergency.

Parent/Guardian	Home Phone ( )	Cell Phone ( )
Workplace	Work Phone ( )	Cell Phone Provider
Address, City, State, Zip if different from child)	Email	

Physician	Address, City State, Zip	Phone ( )
Dentist	Address, City State, Zip	Phone ( )
Hospital	Address, City State, Zip	Phone ( )

Unless indicated above E.A.S.Y will use the following providers: The College of Dentistry, 801 Newton Rd, Iowa City, IA 52242, (319) 335-7499 Iowa City, IA 52245

The University of Iowa 200 Hawkins Dr, Iowa City, IA 52242, (319) 356-2233

Pediatric Associates of Iowa City 1360 N Dodge St #1500, Iowa City, IA 52245, (319) 351-1448

Name of Insurance	Subscriber's Name	Plan ID #

Special Conditions, Disabilities, Allergies, or Medical Information for Emergency Situations

Name any concern that might require special care. Expect and give permission for the center to post the name, photo, and type of health concern the child has that might require an emergency response, eg, food allergy, severe reaction to insect stings, asthma, blood sugar condition, medication problem.

I give consent for my child to participate on group walks. Fieldtrips in a car, van, or public transportation will require a separate permission statement.

Parent/Guardian	Date

Usual Schedule Mon	Tues	Wed	Thur	Fri

Emergency Contacts (a minimum of 2 required)

(Individuals to whom a child may be released if parent/legal guardian is unavailable or who may be contacted in an emergency)

Emergency Contact 1	Home Phone ( )	Cell Phone ( )
Workplace	Work Phone ( )	Relationship to child
Emergency Contact 2	Home Phone ( )	Cell Phone ( )
Workplace	Work Phone ( )	Relationship to child
Emergency Contact 3	Home Phone ( )	Cell Phone ( )
Workplace	Work Phone ( )	Relationship to child
Emergency Contact 4	Home Phone ( )	Cell Phone ( )
Workplace	Work Phone ( )	Relationship to child

Parent/Legal Guardian Consent

As parent/legal guardian, I give consent for my child to receive first aid from facility staff and, if necessary, to be transported to receive medical/surgical/dental care in an emergency. I understand that I will be responsible for all charges not covered by insurance. The information on this form may be shared with staff members who are responsible for supervision of my child. I understand that I will be asked to sign separate consent forms for medication administration, release of confidential information, field trips, and special program activities.

For child pickup and emergencies: If I am unavailable for a routine or emergency pickup of a child, I give consent for the emergency contact person listed previously **to act on my behalf** until I am available. I understand that a photo ID will be requested by staff members to be sure that the person picking up my child is a person who is listed on this form as a person who is authorized to do so. I agree to review and update this information whenever a change occurs and at least annually.

Parent/Guardian	**Date**

Photography Release

E.A.S.Y may take photographs/video tapings of our child for use in classroom projects, portfolios, and displays within the center.

Parent/Guardian	**Date**

I/We do do not **(circle)** give consent that E.A.S.Y/Shimek BASP may take photographs/video tapings of our child and I/We consent that the program may use the photographs/video tapes of our child in promoting the purpose of the Center. We recognize E.A.S.Y/Shimek BASP **will not** identify our child by name in the photographs used. We understand that no financial benefits from the use of the photographs/video tapes are obligated to be paid by us.

Parent/Guardian	**Date**

ATTACHMENT D

Consent to Release and Exchange of Information

A copy of this form is considered as valid as the original. The Contact Person will send copies of this form to all individuals/agencies listed below. Individuals/agencies listed are responsible for providing requested information.

We want to protect student and family confidentiality, while complying with both state and federal law, including but not limited to the Privacy Act of 1974, specifically the Family Educational Rights and Privacy Act (FERPA.) By signing this form, you are giving permission to the individual(s)/organization(s)/agency(ies) listed below to share information which would otherwise be confidential.

- Child/Student ______________________________ Birth date ____________________
  (Legal Last Name) (First) (MI) (Mo Day Yr)

  I give permission for the parties named below to release and receive written and verbal information regarding the above named child/student for the purpose of the release and exchange of educational records and program information to coordinate after school activities with the school day.

- I understand that I may revoke permission by giving written notice to each party named below. I understand
  Elizabeth Retikis
  (Contact Person)
  Shimek Before and After School Program (Shimek BASP) (319) 530-1413
  (Position/Agency) (Phone #)
  can direct me to the shared information upon request.

- The following agencies and organizations will collaborate with one another in planning, coordinating, and delivering services to students receiving services under the program, Shimek BASP being administered by the Iowa City Community School District. Therefore, this form permits the use, disclosure and redisclosure of confidential information for the purpose stated above and delivery of said services.

  I understand that state and federal law prohibits persons that receive mental health, alcohol or drug abuse, and educational records from redisclosing those records without permission. I also understand that not every organization that may receive a record is required to follow federal HIPAA rules governing the use and disclosure of protected health information. [HIPAA is a federal law intended to protect confidentiality of health care information.]

  I HEREBY GIVE PERMISSION TO THE PERSON(S), AGENCY(IES), AND ORGANIZATION(S) THAT RECEIVE RECORDS PURSUANT TO THIS AUTHORIZATION TO RELEASE AND REDISCLOSE THAT RECORD AND THE INFORMATION IN THAT RECORD TO OTHER PERSONS, ORGANIZATIONS, OR AGENCIES LISTED HEREIN FOR THE PURPOSES OUTLINED ABOVE, BUT FOR NO OTHER PURPOSE WHATSOEVER.

1. ICCSD (319)688-1000
   Name of Individual and/or Position and Agency — Phone
   Address: 1725 N. Dodge St. Iowa City, IA, 52245
   Info to share: Written and verbal information about the student, Behavior Management Plans

2. Shimek BASP (319)530-1413
   Name of Individual and/or Position and Agency — Phone
   Address: 1400 Grissell Pl. Iowa City, IA, 52245
   Info to share: Written and verbal information about the student, Behavior Management Plans

ATTACHMENT D

3. ____
Name of Individual and/or Position and Agency Phone

Address: ____

Info to share:

4. ____
Name of Individual and/or Position and Agency Phone

Address: ____

Info to share: ____

- I understand that this permission and release is valid for one year following its execution, and that this permission and release will **expire one year from today's date**. I understand that this permission and release may be revoked. I understand that if this permission is revoked, it may not be possible to continue to participate in certain programs. I will be informed of that possibility if I wish to revoke this permission. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person, agency, or organization that relied on this permission may continue to use records and protected information as needed to complete work that began prior to the revocation of this permission.

Signature ______________________________ Date: ______________
Parent/Legal Guardian

Signature ______________________________ Date: ______________
Student

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW:
My signature authorizes release of all information relating to (check appropriate boxes):

☐ Mental Health/Psychological ☐ Substance Abuse ☐ HIV Status/AIDS related testing

☐ Other (specify)______________

- Signature ______________________________ - Signature ______________________________
Parent/Legal Guardian Date Student Date

- Witness ______________________________ Date: ______________
Name of Individual and/or Position and Agency

SCHOOL-AGE ASSESSMENT & HEALTH FORM
& IMMUNIZATION DECLARATION

1. **HEALTH STATEMENT** - To be completed by parent.

____

Child's Full Name   Birth Date

1. Significant illnesses and surgeries child has had (give age at time):

____

____

2. Any special health-related needs of child (allergies, medications, injuries, etc.):

____

____

2. **PHYSICAL ASSESSMENT**

1. Is there any defect of vision, hearing or speech of which the child care program should be aware, or could compensate by appropriate action?

____

____

2. Is this child subject to any conditions which limit classroom activities or physical education?

____

____

3. Is this child subject to any condition which may result in an emergency situation?

____

____

4. Is this child subject to any mental or physical condition for which he/she should remain under periodic medical observation?

____

____

5. Other information you would like to share:

____

____

____

____

____

FOR CENTERS SERVING SCHOOL-AGE CHILDREN OPERATING IN THE SAME SCHOOL FACILITY IN WHICH THE CHILD ATTENDS SCHOOL:
My signature below certifies that immunization information concerning my child has been provided and is available in the school file.

Parent's Signature_______________________ Date _______________________

BASP Student Demographic Information Form

This information is voluntary and being requested to ensure all programs using District buildings are serving all students and their diverse needs. The Iowa City Community School District has a non-discrimination policy to ensure students are not discriminated against in educational programs and activities.

Student's Name:______________________________ Date:______________

Please fill out the information below by placing an "X" next to the appropriate field:

Funding	Yes	No
Private Pay		
Student receives Childcare Assistance (CCA)		
Students receives 21st CCLC Funding		
Students receives Bridge Care Funding		

Students by Special Services	Yes	No
Student has a Disability		
Student is Free/Reduced Lunch		
Student has Limited English Proficiency (optional)		

Gender	
Female	
Male	

Race/Ethnicity	
(A)Asian	
(B)Black or African American	
(I)American Indian or Alaska Native	
(P)Native Hawaiian/other Pacific Islander	
(W)White	
(H)Hispanic/Latino	

Parent/Guardian Signature______________________________________