FAMILY NAME:		
SHIMEK BASP ENROLLMEN	IT AGREEMEN	IT
I,, understand that I am enrolling my child: _ upcoming school year. (2023-2024)	for the	
Afternoons only (after school until 5:30 p.m.) – Fee:	5240/monthly	
Mornings Only Fee: \$100/monthly		
Full time afternoons & Mornings (after school until 5:3	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 children I am enrolling. This enrollment fee is due before my child of		her
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 scho Community School District and is closed during vacation and incler	1,30	
I understand and agree to these terms.		
Signature of Parent/Guardian	Date	
<u>Tuition Agreement</u>		
I understand I am responsible for paying tuition prior to the first of e \$10 per day for paying tuition after the 1st of the month. If tuition is child will be suspended until all fees and tuition is paid in full. If tuiti the calendar month, the child will be discharged from the program.	not paid by the 8th of the month,	the
Signature of Parent/Guardian	Date	

SHIMEK BASP ENROLLMENT AGREEMENT

	Mornings Only - Fee: \$100/monthly
	I understand that I have an enrollment fee of \$75.00 for the first child children I am enrolling. This enrollment fee is due before my child or
	i understand and agree to these terms.
Date	
of paid by the 5th of the month, that	

Shimek	BASP	Child	Registration

Child's First	Name	Last Nan	ne omog tagofulo	Date of I	Birth _(mer blin)	Sex Sex
Address	ested (fome Phone	City, State, Z	ip		gency Contact 1
Parent/Guardian	1	Home Frome	Home Phon	e	Cell Pho	ne Killo 2 Vottog
Workplace	ofision	Work Phone	Work Phon	ie	Cell Pho	one Provider
Address, City, State,	Zip (if different f	rom child)	Email			к эмино х умену
Cell provider allows us to	o send text alerts in	the event of an emerger	ney.			958kg
Parent/Guardian	Cell Ph	Home Phone	Home Phon	e	Cell Phone	
Workplace	Relatio	Work Phone	Work Phon	ie	Cell Pho	one Provider
Address, City, State,	Zip if different fr	om child)	Email			
				desca	and an then	nt/Legal Cu
Physician	t facility staff an	Address, City S	tate, Zip	consent fo	Phone	are leed insta
Dentist		Address, City S	tate, Zip		Phone	
Hospital	to sign separate	Address, City S	tate, Zip	nirance. 11 si my child	Phone	u campes aoc e esponsible est
Unless indicated above E.A	S.V. will use the follow	ing providers: The College	of Dantistry 901 N	Touton Pd. Iou	va City, IA 50040	(010) 005 7400 low
Name of Insurance		sity of Iowa 200 Hawkins I of Iowa City 1360 N Dodge Subscriber's I	e St #1500, Iowa Ci			ems of inordina general thas large who is in #
		ally.	unna fasel fa	bas amoso	त्रहार के तीन के शहर	mation whene
Special Conditions, E Name any concern that a concern the child has the condition, medication pr	might require specia at might require an roblem.	l care. Expect and give p	permission for th , food allergy, sev	e center to po vere reaction	ost the name, ph to insect stings,	
						in the center.
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I give consent for m			s. Fieldtrips ir	a car, van	, or public tra	ansportation w
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Parent/Guardian	the photograph	tits from the use of	erred Isionenil	on tarii be	Date	ographs used.
					-09 (1)	and an at they
Usual Schedule Mon	Tues	Wed	T	nur	Fri	

golis	Shirnek RASP Child Reelers	
	Contacts (a minimum of 2 requ	
(Individuals to whom a child may be released if pare	ent/legal guardian is unavailable or who m	ay 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
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Parent/Legal Guardian Consent		
for all charges not covered by insurance. That are responsible for supervision of my child	he information on this form may be . I understand that I will be asked t	e shared with staff members who to sign separate consent forms for
for all charges not covered by insurance. The are responsible for supervision of my child medication administration, release of configuration for child pickup and emergencies: If I ame consent for the emergency contact person lunderstand that a photo ID will be request a person who is listed on this form as a per	he information on this form may be a lift of the lift	e shared with staff members who to sign separate consent forms for d special program activities. ency pickup of a child, I give thalf until I am available. It the person picking up my child is
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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 WOI

Child/Stud	dent			Birth date	
Cimabia	(Legal Last Name)	(First)	(MI)		lo Day Yr)
above nan	mission for the parties named bel ned child/student for the purpose on to coordinate after school active and that I may revoke permission	of the relea	ase and exchang he school day.	ge of educational record	ls and program
	(Contact Person)			
Shimek	Before and After School Progra	m (Shime	k BASP)	(319) 530-141	3
can direct	Position/Agency) me to the shared information upo	on request	plane in restu	(Phone #)	setter or rev ited
Can direct	the to the shared information upo	m request.		ng cast on palating to the palating	est settlet et seet [
The follow	wing agencies and organizations	will collabo	orate with one a	nother in planning, coo	rdinating, and being
delivering	services to students receiving se red by the Iowa City Community	School Die	r me program, strict Therefor	re, this form permits the	
redisclosu	are of confidential information for	the purpos	se stated above	and delivery of said ser	vices.
CONCALION	al records from redisclosing those	e records w	othout permissi	on. I also understand the	nat not every
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ATTACHMENT D

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SCHOOL-AGE ASSESSMENT & HEALTH FORM & IMMUNIZATION DECLARATION

Child's Full Name	Birth Date
Significant illnesses and surgeries ch	ild has had (give age at time):
2. Any special health-related needs of ci	hild (allergies, medications, injuries, etc.):
2. PHYSICAL ASSESSMENT	
1. Is there any defect of vision, hearing could compensate by appropriate action?	or speech of which the child care program should be aware, or
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 predical observation?	physical condition for which he/she should remain under periodic
5. Other information you would like to s	share:
FACILITY IN W	L-AGE CHILDREN OPERATING IN THE SAME SCHOOL HICH THE CHILD ATTENDS SCHOOL: unization information concerning my child has been provided
Parent's Signature	Date

SCHOOL AGE ASSESSMENT & HEALTH FORM & IMMUNICATION DECLARATION

2 PHYSICAL ASSESSMENT
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?
S. Other information you would like to share:
FOR CENTERS SERVING SCHOOL-AGE CHU DREN OPERATING IN THE SAME SCHOOL FACILITY IN WHICH THE CHILD ATTENDS SCHOOL My signature below certifies that immunication information concerning my child has been provided available in the school file.
Parent's Signature Date Total



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:	(H)Hispanic/Letino

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	September 10 mographic in
(I)American Indian or Alaska Native	This information is voluntary and being requested to District buildings are serving all students and their div
* /	Community School District has a non-discrimination pare not discriminated against in educational program
(W)White	
(H)Hispanic/Latino	Student's Name:
next to the appropriate	Please fill out the information below by placing an "X"
Parent/Guardian Signature_	Stude the section of