

Carver Community Organization 400 S.E. 8th Street Evansville, Indiana 47713 (812) 423-2612

- Summer Camp Application -

Before your child or children can begin the program, make sure the following forms are completed:

0	Completed Summer	Camp Program	Application for Date:	
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- One-time, non-refundable activity fee of \$60.00 per child to reserve your child's spot
- Parent/Guardian's Pay Stubs (a month's worth of income)
- CCDF Voucher Provider Transfer Form (if on CCDF program)
- CACFP Application & Enrollment Form (Case Number if any member of your household receives Food Stamps or State TANF assistance)

Return all completed applications to the Intake Specialist:

Carver Community Organization

Monday through Friday from 6:00 am - 5:30 pm. **LATE FEES APPLY AFTER 5:30 pm

Carver Community Organization, Inc. 400 S. E. 8th Street Evansville, IN 47713 Phone: (812) 423-2612 Fax: (812) 423-6941 E-Mail: carverorg@carverorg.org

Youth Program Summer Camp Application

*A one-time activity fee of \$60.00 is due with application (**Non-refundable) \$76.00 a week per child Dates of Operation: Monday-Friday 6:00am—5:30pm

Pick up *promptly* at 5:30 pm

Child's Name:		Nickname(?):		
Gender	Age	DOB// Grade		
Name of School Attended:			-	
	Fa	amily Information		
Mother/Guardian's Name:		Legal custody of child: 🗌 YES	□ мо	
Address & Zip Code:			_	
Home Phone:		Cell Phone:		
Email Address:				
Place of Employment:			-	
Address & Zip code:		Work Phone:		
Father/Guardian's Name:		Legal custody of child: YES	□ NO	
Address & Zip Code:			-	
Home Phone:		Cell Phone:		
Email Address:				
Place of Employment:			-	
Address & Zip code:		Work Phone:	_	
List names of other children w	ho attend Car	ver Day Care and Preschool (if applicable)		

Hours of Operation

6:00 am-5:30 pm
**LATE FEES APPLY AFTER 5:30 pm

*Authorization for Pick-Up

LATE FEE NOTE - 3 LATE OCCURANCES COULD RESULT IN SUMMER CAMP TERMINATION!!

Emergency Contacts

Please list three (3) responsible adult persons who can be contacted in case parent(s)/guardian(s) cannot be reached in the case of an emergency:

Name:	Relationship:
Telephone #:	Alternate Phone #:
Employer:	
Name:	Relationship:
Telephone #:	Alternate Phone #:
Employer:	
Name:	Relationship:
Telephone #:	Alternate Phone #:
Employer:	
Special Medical Health Need(s):	
Signature of Parent or Guardian	Date

Emergency Medical Authorization

*Local Telephones Numbers Required

I agree, and by my signature, give consent, that in case of an accident or illness of a serious nature, my child will be given emergency medical care, and if necessary, transported by ambulance. I understand that I will be contacted immediately, or as soon as possible should I be away from the phone numbers given with this application.

Name of Parent/Guard	lian:		<u>.</u>	
Phone # 1:		Emergen	ıcy#:	
My child is insured:	☐ Yes	□ No		
In case of emergency, v	which hospi	cal would you	prefer your children t	o be transported?
Physician's Name:				
Physician's Phone Num	ıber:			
Physician's Address:				
City:	_ State: _		Zip Code:	
Dentist's Name:		·····		
Dentist's Phone Numbe	er:			
Dentist's Address:				
City:	S	tate:	Zip Code:	<u>.</u>
Signa	ture of Parent			Date

Behavior and Habits Form

1.	How does your child react to other children?			
2.	How does your child react to adults?			
}.	How does your child react to new situations?			
•	Is he/she insecure?If so, please explain:			
	Does he/she show independence □ or dependence □?			
	What is your child's attitude toward discipline?			
	How does your child show fear?			
	What are some of the things that make your child afraid? (i.e.: the dark, heights, dogs, cats, etc.)			
	Does he/she share things willingly Yes □No □			
٠	Is he/she destructive? Yes □No □ If yes, please explain:			
	How does your child react to adults?			
	Is he/she friendly in most situations? Yes \square No \square Shy? Yes \square No \square			
	Aggressive? Yes □No □ Withdrawn? Yes □ No □			
	How does your child reveal his/her feelings?			
	What makes your child upset?			
	Is there a pet in the household? Yes \square No \square			
	If yes, how does your child react with the pet?			
	If no, how does your child react to animals and pets?			
ć	rent/Guardian Signature Date			

Eating Habits

1.	. Does your child have any type of eating disorders? Yes □No □ If so, please explain:			
2,	2. Does your child have any food allergies or food sensitivities? Yes □No □ If so, please fill out the following chart, along with official document from ! Food Allergens and Sensitivities If your child is allergic or sensitive to certain foods, please specify a sensitive to certain foods.	•		
	Signature of Parent or Guardian Date			
	Water Activities			
	1. Does your child know how to swim? Yes ☐ No ☐			
	 Is your child able to swim more the 12.5 yards without assistance Do you want your child to participate in swimming activities (inc Yes □ No □ 			
	Signature of Parent or Guardian Date			
	Allergies/Sensitivities			
	Does your child have any allergies or sensitivities? Yes \Box No \Box			
	If so, please fill out the following chart, along with official document from Pl <u>Allergens and Sensitivities</u>	hysician		
	If your child is allergic or sensitive to certain foods, please specify al	ong with reactions:		
 Pa	Parent/Guardian Signature	Date		

DISCIPLINE AND GUIDANCE POLICY

Brief supervised separation from the group may be used, if necessary, which is referred to as "reflection period". Most children are old enough to understand consequence both negative and positive.

Children shall not be humiliated or subjected to abusive or profane language. Punishment shall not be associated with food.

CAUSES OF DISMISSAL

- 1. Violent or threatening behavior (profane language, spitting, wild temper tantrums, etc...)
- Child causing physical harm to themselves, other children, or staff (fighting, kicking, biting, etc...)
- Child refusing to participate or cooperate in every segment of Summer Camp

4. Non-payment of required fees.	
I understand the discipline guidance policy, with th discretion of the Carver Community Organization I	0 11
Signature of Parent or Guardian	Date
AVE ACTEUMENT	

INTAKE AGREEMENT

LATE POLICY: A Carver staff member will attempt to call all persons/numbers listed on application in cases where the child has not been picked up by the end of the day's program (5:30). Parents will be charged \$1.00 for each minute after the first 5 minutes the child remains at the daycare. Late Fee Payment must be paid in full before your child can return to camp.

If attempts have been made to contact you as well as the listed responsible adults and your child has not been picked up by 6:30 pm, Child Protective Services (425-2124) will be notified.

		·	
1.	I understand	that my child will	only be released to the parent(s) named (pg. 2) or authorized (pg. 3)
	Yes 🗌	No 🗆	
2.	In case of seri	ous injury or illne	ess, I grant permission for emergency medical treatment
	Yes 🗌	No 🗆	
3.	•	ver Community o vities outside cam	rganization and its designees to transport my child to and from field trips- p Facilities.
	Yes 🗌	No □	
4.	I understand t	hat payment for S	Summer Camp is due each Monday
	Yes 🗆	No □	•
5.	I understand I admission	must supply the	Summer Camp with my child's current Immunization Record prior to
	Yes 🗆	No □	
6.	I understand performance	that the Summer	Camp staff will notify parent(s) of any issues pertaining to their child's
	Yes □	No □	
			
	Signature of Pa	arent or Guardian	n Date

MEDIA RELEASE FORM

Dear Parent(s):

The United Way of Southwestern Indiana and various other funding sources, local newspapers and other organizations occasionally request photographs of the activities provided by Carver Community Organization, Inc.

We need a release from you, the parent / guardian, before releasing any photographs of your child to one of these funding sources or news media.

Thank you.

Please check one of the following statements.

Υ	Yes, I give my permission for		's picture to be
	Cl	nild(ren)'s name	•
	taken and released for publicity.		
Υ	No, I do not give my permission for_	Child(ren)'s name	's pícture to be
	taken and released for publicity.		
		144 - 1-1-144 - 144 - 	
Sig	nature of Parent or Guardian		Date

Parent - Provider Transportation Agreement

Child Care Program located at Carver Community Organization Summer Camp

	9 3	on for Carver Community Organization, Inc. to
(Nar	ne of parent)	
	oort my child(ren) (Name(s) of child(ren e purpose of: (check all that apply):))
	Field tri	ps .
	Excursion	ons to the park
	Emerge	ncy purposes
	Any reas	son deemed necessary by the program
It is ag	reed that: The caregiver will never leave my child(form oftransportation.	ren) unattended in any motor vehicle or other
2.	Each child will board or leave a vehicle is	n a safe & supervised manner.
3.	My child(ren) will be secured in safety so age of thechild(ren) in accordance with	eats or by safety belts as appropriate for the he law.
4.		child(ren) will have current registration and I by a person who is at least 18 years of age and
S.	The CCOSAC Staff will notify me in advatransported whilein care.	nce of any instance where my child(ren) will b
6.	The driver(s) is considered Carver's emp CCDF ProviderEligibility Standards.	loyee or volunteer and therefore has met ALL
arent o	r Guardian Signature)	(Date)
rogram	Director Signature)	(Date)

FINANCIAL RESPONSIBILITY FORM

All fees are due and payable at the time of service. Fees for the current week are due no later than Friday by 5:30 p.m. If full payment on your account isn't received by the following Monday by noon, your account will be suspended, and Carver will not be able to accept your child for care the next day. All accrued fees must be paid before service can resume. You will be contacted by a Carver Staff Member to request payment of your account. You will have 30 days to respond. If you do not respond within the 30-day timeframe after being contacted for payment, your account will be turned over to a collection agency. We will set up a payment plan for clients who contact us to pay their past due fees if contacted before your account is turned over to a collection agency. However, you will be turned over to a collection agency if you do not keep your agreed payment arrangement. By signing below, you acknowledge your understanding and agreement of the terms for payment for services received from Carver Community Organization, Inc., and the collection procedure required for services received. By signing below, you also acknowledge that you are the person responsible for payment(s) to be made to Carver Community Organization, Inc.

I also understand that I am responsible for any attornunpaid balances for services I received. I agree that to claims.	-		_
Printed Name of person Financially responsible for c	hild	Date	
Signature of person financially responsible		Date	
ATTEST To the best of my knowledge, all the information pro	•	nd factual.	
Signature of official completing form	Date		
Relationship to Child:			

FAMILY AND SOCIAL SERVICES ADMINISTRATION - MS02

402 W. Washington St., Room W362 Indianapolis, IN 46204

Name of child (last, first)		Date of birth (month, day, year)	Oate of admission (month, day, year)
Address (number and street, city, state	, and ZIP code)		
Child lives with (relationship)	Name		Telephone number
			()
	MEDI	CAL HISTORY	
Communicable Disease	Month / Year	Condition	Explain if present
		Allergies:	
		Handicapping conditions:	
Screenings	Result / Date (month, day, year)		
TB Risk / Symptom Developmental Screen		Other:	
Lead			
Load	1		
	PHYSICA	LEXAMINATION	
Date of exam (month, day, year)		Age of child	
		1	
Skin		Heart	
Lymphnodes		Lungs	
Eyes		Abdomen	
Ears		Genitalia	
Nasopharynx		Skeleton	
Teeth and Mouth		Other:	
Note any unusual findings:			
• • • • • • • • • • • • • • • • • • • •			

			participation in normal activities (including sports)?
☐ Yes ☐ No If Yes, what modifie	cation of normal activities would be necessary l	to protect the child and the child's classmat	es;
	special routines which should be included in th	e center's plans for this child's activities? E	xplain:
☐ Yes ☐ No			

	-		

					IEST (indicate m		CONTRACTOR AND ADDRESS.		
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DTaP / DT	-		1						
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Ţ	11	2	3	4	5				
IPV (Polio)			i i	!					
				<u></u>	l				
	1	2	3	4	5				
Influenza (Flu)									
Measles Mumps	1	2							
Rubella (MMR)									
	4	^	•						
Potovisus /PCEV	1	2	3						
Rotavirus (RGE)									
	1	2							
Varicella			or Chicker	Pox Disease	Month / year	7			
(Varivax)			or Omeren	Pox Disease					
	1	2	3	4					
Pneumococcal (PCV) (Prevnar)									
(PCV) (Prevnar)									
	1	2							
НЕР А									
	-								
	1	2	3						
HBV (HEP B)									
· · · · · · · · · · · · · · · · · · ·	L								
Recommended yes e of physician / nurse p	arly. practitioner / phy	ysician assistant cc	mpleting form (p	lease print)		Telephone	number		
ature of physician / nur				• •		()		



INSTRUCTIONS:

CHILD CARE AND DEVELOPMENT FUND (CCDF) PROVIDER INFORMATION State Form 56903 (RZ / 4/21) FAMILY AND SOCIAL, SERVICES ADMINISTRATION

Eligible providers must demonstrate compliance with CCDF Minimum Standards prior to participation in this program. The provider must complete all information and sign the form. PLEASE NOTE:

PARENT / GUARDIAN: Your caregiver must complete this information in its entirety. Your CCDF provider must allow unscheduled visits by a parent or legal guardian to their child care program during the hours the child care program is in operation. Please bring the completed form to your appointment to assist in prompt completion of your child care vouchers. If you wish to make a provider change, you must obtain new vouchers prior to attendence or payment for care may become your responsibility. If you have any questions, please contact your local intake office.

Money of agents I amendian					
Name of parent, guardian		,	•	Date completed (month, day, year)	
Name of caregiver Carver Daycare & Preschool		AND THE REAL PROPERTY OF THE P	THE RESERVE OF THE PROPERTY OF	THE RESERVED THE PROPERTY OF THE PERSON OF T	
Name of bushess <i>(if applicable)</i> Carver Community Organization				Employer Identification Number (EIN) of business (if applicable) 35-0869030	rf business (if applicable)
Address where care is provided (number and street, city, state, and ZIP code) 400 SE. 8th Street Evansville, IN 47713	city, state, and ZIP code) \ 47713	TOTAL SEAL OF STREET,		County	4-
Type of provider Licensed Home Licensed Center		☐ License Exempt Home	License Exempt Facility	Providi	i's Home
License / registration / exemption number 14590	Is this a Paths to Quality (PTQ) level Increase?	oN 🛭	elaphone number		
Hours of operation (Le. 7 AM to 6 PM) 6:00am to 1am	Days of o	Days of operation (Gheck all that apply.) Monday	☐ Wednesday [Thursday Friday Sk	Saturday Sunday
Is this a provider change?	☐ Yes ☐ No	If yes, on what date will the child begin care? (month, day, year)	? (month, day, year)	actho	1.
Name of Child (First and Last)	Age of Child Years / Months	Kindergarten (Indicate HD for Half Day or FD for Full Day.)	Current Charge (List charges for school-age school year.) Week / Day / Hour	Charge for Next Age Group (If child is currently two (2), list charge at age three (3), Week / Day / Hour	School-Age Other (List charges for summer, evening care,) Week / Day / Hour
				44****	
Are you related to the child(ren) listed above?	If Yes, please explain.				
	FORS	FOR SCHOOL AGE OTHER KINDERGARTEN FULL DAY CARE	RGARTEN FULL DAY CARE		
Date school year begins (month, dey, year) Date	Date school year ends (month, day, year) Does school-age child need break care vouchers? ☐ Yes ☐ No	reak care Is this form On My	Is this form On My Way Pre-K wraparound If the ans or break care? Tes No a school	If the answer to either question is Yes, a school calendar <u>must</u> be provided.
		PROVIDER AFFIRMATION	MATION	ALL ALL MANAGEMENT OF THE PROPERTY OF THE PROP	
l affirm the information provided on this application form is true and correct. Further, I affirm child care will be provided at the address listed above and agree to comply with the rules and regulations of the CCDF program available on www.child.care.nigoc. . I also understand I must allow unscheduled visits by a parent or legal guardian to my child care program during the hours my child care program is in operation. In signing this application, I certify I am the individual listed above or the authorized designee.	cation form is true and correct. Finder in gov. I also understand I made in the individual listed above o	rrect. Further, I affirm child care will be tand I must allow unscheduled visits b above or the authorized designee.	e provided at the address listed y a parent or legal guardian to	above and agree to comply with the care program during the h	te rules and regulations of the lours my child care program is in
Signature of provider		Printed name of provider		Date	Date (month, day, year)
				_	



Enlightening Generations

To whom it May Concern:

I hereby authorize and request that Carver Community Organization to be given the information specified, which is necessary to determine my family's income range based on CBDG (Community Development Block Grant) guidelines. This is without liability to me whatsoever and I may retain a copy of this authorization for my records.

Address:			
City:	State:	Zip Code:	
Social Security Number:			
Signature of Parent or Guardian		Date	

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