



# GRASP

at  
**Four Corners School**

## Program Begins on the First Day of School!

Fully licensed by the EEC

### Daily Schedule

2:55pm	Arrival, Attendance
3:00pm	Hand washing, Snack
3:15pm	Free Play/ Outdoor Play
4:00pm	Homework Time
4:30pm	Enrichment/Gym
5:30pm	Pick-Up



### Tuition

*First Child:*

\$12 Per Day, \$24 Per Half Day

*Additional Siblings:*

\$11 Per Day, \$22 Per Half Day

*Minimum of 2 days per week*

### Registration is on a rolling basis. How to Register:

1. Contact the Recreation Dept for registration packet
2. Fill out Registration Form with Days Enrolled
3. Complete Child Information Form
4. Complete Transportation Plan Form
5. Be sure to read Parent Handbook
6. Submit payment for September Fees

### Programming:

Activities include arts and crafts, sports, drama, cooperative games, indoor and outdoor free play, snack and more!

### Pick Up:

Program ends at 5:30pm. Please come in to sign child out each day at the Glass Doors. If the adult picking up a child is unfamiliar, their ID will be checked against the child's approved pick-up list. If you need to pick up your child early, please contact the Site Coordinator in advance.



### Greenfield Recreation Department

20 Sanderson Street

Greenfield, MA 01301

Phone: 413-772-1553 Fax: 413-773-0115

[www.greenfieldrecreation.com](http://www.greenfieldrecreation.com)





Phone: 413-772-1553

Fax: 413-773-0115

# 2021-2022 Greenfield Recreation After School Program Registration Form

ONE PER HOUSEHOLD. PLEASE PRINT CLEARLY.

Parent/Guardian Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Email \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Emergency Contact other than yourself. Name \_\_\_\_\_ Phone \_\_\_\_\_

Medical Conditions or physical limitations / restrictions \_\_\_\_\_

## LIST EACH PARTICIPANT'S INFORMATION; USE GRADE YOUR CHILD IS IN

Name	M/F	Date of Birth	Grade	Age	Program Name
					Four Corners After School
					Four Corners After School
					Four Corners After School
					Four Corners After School

Please select the days your child(ren) will attend. Minimum of two days required.

Your child will automatically be registered for your selected days for the entire 2021-2022 school year.

Monday     Tuesday     Wednesday     Thursday     Friday

**Release and Waiver Agreement:** I the undersigned do hereby consent to my or my child's participation in voluntary athletic or recreation programs of the Town of Greenfield Recreation Department. I also agree to forever release the Town of Greenfield, the Recreation Commission, and all their employees, agents, board members, volunteers and any and all individuals and organizations assisting or participating in voluntary athletic or recreation programs of the Town of Greenfield ("the Releasees") from any and all claims, rights of action and causes of action that may have arisen in the past, or may arise in the future, directly or indirectly, from personal injuries to my child and/or myself or property damage resulting from my child's participation and/or my participation in the Town of Greenfield Recreation Department voluntary athletic or recreation programs. Consent: I hereby consent to and authorize Greenfield Recreation Department the right to publish, reproduce and use for advertising or any other purpose, any photograph, video image, an audio recording or other likeness of my child or family member. I further affirm that I have read this Consent and Release Form and that I understand the contents of this Form. I understand that my child's participation and/or my participation in these programs is voluntary and that my child and I are free to choose not to participate in said programs. By signing this Form, I affirm that I have decided to allow my child to participate in the Town of Greenfield Recreation Department's athletic or recreation programs with full knowledge that the Releasees will not be liable to anyone for personal injuries and property damage my child or I may suffer in voluntary Town athletic or recreation programs.

PRINT NAME OF PARENT OR GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE OF PARENT OR GUARDIAN \_\_\_\_\_

## Registration Guidelines

Use one form for multiple class registrations.

Complete this form and be sure to note:

1. All contact information is complete.
2. Include payment for all classes. Checks payable to Town of Greenfield Recreation Department.

3. Mail to:  
Greenfield Recreation  
20 Sanderson Street  
Greenfield, MA 01301



OFFICE USE ONLY

Paid \_\_\_\_\_ Entered \_\_\_\_\_



**CHILD INFORMATION FORM 2021-2022**  
**GREENFIELD RECREATION AFTER SCHOOL PROGRAM AT FOUR CORNERS SCHOOL**

**CHILD INFORMATION**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Identifying Marks: \_\_\_\_\_

Please list any medical needs, dietary restrictions, allergies, etc. \_\_\_\_\_

Does your child carry an Emergency Medication (EpiPen® or inhaler)? Yes \_\_\_\_\_ No \_\_\_\_\_

\*PLEASE NOTE: If your child carries an EpiPen® or inhaler, one must be supplied to GRASP

Child's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Child's Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital Preferred: \_\_\_\_\_ Health Insurance Carrier & Policy #: \_\_\_\_\_

Does your child have a chronic health condition? YES  NO  If yes, an individual health plan must be completed.

Are there any custody agreements, court orders, or restraining orders that pertain to the child? YES  NO  If yes, please attach

**Please attach a  
current  
photograph of  
your child.**

**PARENT/GUARDIAN INFORMATION**

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Address: \_\_\_\_\_ Town: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Best # to Reach: \_\_\_\_\_ Email Address: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Address: \_\_\_\_\_ Town: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Best # to Reach: \_\_\_\_\_ Email Address: \_\_\_\_\_

**ADDITIONAL PICK-UP CONSENT**

In the event that I cannot pick up my child for any reason, I authorize GRASP to release my child to the following individuals:

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Phone: \_\_\_\_\_

**EMERGENCY CONTACTS**

If Parent(s)/Guardian(s) cannot be reached.

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Phone: \_\_\_\_\_

**PLEASE COMPLETE BOTH SIDES**

**CONSENT**

I authorize GRASP staff to give my child first aid when appropriate. If my child requires further medical attention, 911 will be called and I will be notified immediately. I understand if I cannot be reached, an emergency contact will be notified. If my child needs to be taken to the nearest medical care facility or to my preferred hospital listed above by ambulance, one staff person will accompany my child. I also give permission to the attending physician to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child as indicated. I will accept responsibility for any expenses incurred in handling this emergency care.

Parent/Guardian (Print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**HEALTH HISTORY AND IMMUNIZATION RECORDS**

I attest that my child’s health and immunization records are on file with the Greenfield Public Schools.

Parent/Guardian (Print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**RELEASE OF INFORMATION**

For the purpose of continuity of care, I hereby give permission for Greenfield Public Schools to release information to the GRASP Staff for my child. Information may be shared in written or verbal format.

Parent/Guardian (Print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PERMISSION TO APPLY HAND SANITIZER**

I give my child permission to use hand sanitizer containing at least 60% alcohol to prevent the spread of COVID-19.

I do \_\_\_\_\_ I do NOT \_\_\_\_\_ give permission for my child to use hand sanitizer. INITIALED: \_\_\_\_\_

**PUBLICITY/PHOTO RELEASE**

I understand that my child may be photographed or videotaped by the Greenfield Recreation Department for use on website, in promotional/ publication materials, and for grant purposes. Newspaper and television staff may also photograph or videotape my child should they feature the program.

I do \_\_\_\_\_ I do NOT \_\_\_\_\_ give permission for my child to be photographed/videotaped. INITIALED: \_\_\_\_\_

**PARENT HANDBOOK ACKNOWLEDGEMENT**

I have read and understand all of the policies in the Greenfield Recreation After School Program (GRASP) at Four Corners School as stated in this handbook. I agree to follow the handbook policies accordingly. I do understand that all policies listed in this handbook will be enforced, and failure to comply with the policies, is reason for immediate termination.

Parent/Guardian (Print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ANYTHING ELSE WE SHOULD KNOW?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please return this form to the Greenfield Recreation Department, 20 Sanderson Street, Greenfield, MA 01301  
Phone: (413)772-1553 Fax: (413)773-0115 Website: [www.greenfieldrecreation.com](http://www.greenfieldrecreation.com)

This form must be completed and submitted before your child begins the program. It will be placed in their file for reference.

**FOR OFFICE USE ONLY:**

DATE OF ADMISSION: \_\_\_\_\_

REVIEWED BY: \_\_\_\_\_

# GRASP at Four Corners School

## Transportation Plan and Authorization

CHILD'S NAME: \_\_\_\_\_

**MY CHILD WILL ARRIVE AT THE PROGRAM:**

**MY CHILD WILL DEPART FROM THE PROGRAM:**

\_\_\_ ESCORTED BY SCHOOL PERSONNEL

\_\_\_ PARENT/GUARDIAN OR AUTHORIZED PICK UP

PARENT /GUARDIAN SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_



**MEDICATION CONSENT FORM 606 CMR 7.11(2)(b)**

Name of child: \_\_\_\_\_

Name of medication: \_\_\_\_\_

Please  one of the following: Prescription: \_\_\_\_\_ Oral/Non-Prescription: \_\_\_\_\_

Unanticipated Non-Prescription for mild symptoms \_\_\_\_\_

Topical Non-Prescription (**applied to open wound/ broken skin**) \_\_\_\_\_

My child has previously taken this medication \_\_\_\_\_

My child has **not** previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan \_\_\_\_\_

Dosage: \_\_\_\_\_

Date(s) medication to be given: \_\_\_\_\_

Times medication to be given: \_\_\_\_\_

Reasons for medication: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Directions for storage: \_\_\_\_\_

Name and phone number of the prescribing health care practitioner:  
\_\_\_\_\_

**Child's Health Care Practitioner Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

I, \_\_\_\_\_, (parent or guardian) gives permission  
(print name)

**to authorize educator(s) to administer medication to my child as indicated above.**

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

For topical, non-prescription **NOT** applied to open wound / broken skin (**parent signature only**)



**Department of  
Early Education and Care**  
THE COMMONWEALTH OF MASSACHUSETTS

## **Small Group, Large Group and School Age Child Care Licensing**

### **POLICY STATEMENT: Individual Health Care Plans**

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All programs must maintain as part of a child's record, an Individual Health Care Plan (IHCP) for each child with a chronic medical condition which has been diagnosed by a licensed health care provider as required by 606 CMR 7.11(3)(a)-(c). An IHCP ensures that a child with a chronic medical condition receives health care services he or she may need while attending the program.

Programs must develop an IHCP in collaboration with the parents/guardians, school age child who is 9 years or older (when appropriate), program educators and the child's licensed health care practitioner, who must authorize the IHCP.

#### ***The IHCP must include the following:***

- \* description of the chronic condition which has been diagnosed by a licensed health care practitioner
- \* description of the symptoms of the condition
- \* outline of any medical treatment that may be necessary while the child is in care
- \* description of the potential side effects of the treatment
- \* outline of the potential consequences to the child's health if the treatment is not administered

An educator must have successfully completed training relative to a child's ICHP. This training must be given by the child's health care practitioner or, with the child's health care practitioner's written consent, by the child's parent or the program's health care consultant. The training must specifically address the child's medical condition, medication and other treatment needs. Some examples of an ICHP would include children with asthmatic conditions, allergic reactions, ADHD, or diabetic conditions. IHCP's are *not* required for children *without* chronic conditions needing oral or topical medications.

In the event of an *unanticipated*, non-life-threatening condition requiring treatment (as specified in the IHCP) the educator must make a reasonable attempt to contact the parents/guardians prior to administering the unanticipated medication or beginning the unanticipated treatment. If parent/guardians cannot be reached immediately, they should be notified as soon as possible after the medication or treatment has been administered to the child.

Educators must ensure that they document the administration of all medications and medical treatments in the child's medication/treatment log.

Written parental and licensed health care practitioner authorization shall be valid for one year, unless withdrawn sooner and must be renewed annually, *or when the child's condition changes*, for administration of medication and/or treatment to continue.

Additional information regarding Individual Health Care Plans:

- Educators with written parental consent and authorization of a licensed health care practitioner may develop and implement an Individual Health Care Plan that permits older school age children *who are 9 years or older* to carry their own inhalers and epinephrine auto-injectors and use them as needed, without the direct supervision of an educator. All educators must be aware of how the inhaler or epinephrine auto-injector will be kept secure from access by other children in the program. Whenever an IHCP provides for a child to carry his or her own medication, the licensee must maintain an on-site back-up supply of the medication for use as needed.
- A copy of the IHCP must be maintained in the child's file. It is recommended that a copy of the IHCP also be located in the classroom.
- There must be one person trained in the implementation of a child's IHCP whenever the child is in the care of the program.
- In addition to a licensed health care practitioner, training to implement an IHCP may also be given by the child's parent or the program's health care consultant with the licensed health care practitioner's written consent.

Additional medication requirements to consider:

- Emergency medication such as Epipens must be immediately available for use. For example, Epipens must be brought with children for outdoor play or walks as required by 7.11(2)(f). Training by a licensed health care practitioner for the specific administration of an Epipen is **highly** recommended but not required.
- All staff who administer medication of any kind must be trained in medication administration as required by 7.11(1)(b)2.



## Individual Health Care Plan Form

**Plan must be renewed annually or when child's condition changes**

*Check all that apply....*

**Plan was created by:**

- Parent
- Doctor or Licensed Practitioner
- Program's Health Care Consultant
- Older school age child (9+ yrs. of age)
- Other: \_\_\_\_\_

**Plan is maintained by:**

- Director
- Assistant Director
- Child's Educator
- Other: \_\_\_\_\_

Name of child:	Date:
Any change to the child's Health Care Plan? <b>YES</b> (indicate changes below) <b>NO</b> (updated physician/parental signatures required)	
Name of chronic health care condition:	
Description of chronic health care condition:	
Symptoms:	
Medical treatment necessary while at the program:	
Potential side effects of treatment:	
Potential consequences if treatment is not administered:	
Name of educators that received training addressing the medical condition:	
Person who trained the educator (child's Health Care Practitioner, child's parent, program's Health Care Consultant):	

Name of Licensed Health Care Practitioner (please print): \_\_\_\_\_

Licensed Health Care Practitioner authorization: \_\_\_\_\_ Date: \_\_\_\_\_

Parental/Guardian consent: \_\_\_\_\_ Date: \_\_\_\_\_

***For Older Children ONLY (9+ years of age)***

With written parental consent and authorization of a licensed health care practitioner, this Individual Health Care Plan permits older school age children to carry their own inhaler and/or epinephrine auto-injector and use them as needed without the direct supervision of an educator.

The educator is aware of the contents and requirements of the child's Individual Health Care Plan specifying how the inhaler or epinephrine auto-injector will be kept secure from access by other children in the program. Whenever an Individual Health Care Plan provides for a child to carry his or her own medication, the licensee must maintain on-site a back-up supply of the medication for use as needed.

Age of child: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Back-up medication received?    YES    NO

Parent signature: \_\_\_\_\_ Date: \_\_\_\_\_

Administrator's signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Greenfield Recreation After School Program Payment Plan Authorization Form



PLEASE PRINT LEGIBLY

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

GRASP Site: Federal Street Four Corners

Cardholder's Name: \_\_\_\_\_  
FIRST MIDDLE INITIAL LAST

Email: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Discover

Mastercard

Visa

Card Number: \_\_\_\_\_ Expiration: \_\_\_\_/\_\_\_\_/\_\_\_\_ CVV Code: \_\_\_\_\_

Billing Address: \_\_\_\_\_  
STREET CITY STATE ZIP

Monthly Payment Date: 1st (or next business day) Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*Payments are processed in advance. For example, February Tuition is paid on February 1<sup>st</sup>.*

#### Pay Monthly Tuition

- Monthly tuition is based upon number of days enrolled

Would you like a copy of your monthly invoice?  No Invoice  Emailed  Printed

Would you like a receipt of each month's payment?  No Receipt  Emailed  Printed

I authorize the Greenfield Recreation Department (service provider) to charge my credit/debit card as identified above to the terms stated here. This authorization shall remain in effect until the service provider receives written notification from me of intent to terminate at such time and in such a manner as to afford the service provider reasonable opportunity to act (minimum of 30 days).

I understand my payment will be processed on the 1<sup>st</sup> of every month, or the next business day. I further understand that payment amount will vary from month to month based on the number of days my child is enrolled in the program.

I represent and warrant that I am authorized to execute this payment authorization for the purpose of implementing this payment plan. I indemnify and hold the service provider, the bank, and the merchant harmless for damage, loss or claim resulting from all authorized actions hereunder.

\_\_\_\_\_  
Customer Signature

\_\_\_\_\_  
Date