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
4:15pm	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:

Actvities 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

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Fax: 413-773-0115

2022-2023 Greenfield Recreation After School Program Registration Form

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 City of Greenfield Recreation Department.**
3. **Mail to:**
   Greenfield Recreation
   20 Sanderson Street
   Greenfield, MA 01301

OFFICE USE ONLY
Paid _____ Entered _____

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	Gender	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 2022-2023 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 City of Greenfield Recreation Department. I also agree to forever release the City 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 City 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 City 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 City 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 City athletic or recreation programs.

PRINT NAME OF PARENT OR GUARDIAN _____ DATE _____

SIGNATURE OF PARENT OR GUARDIAN _____

CHILD INFORMATION FORM 2022-2023
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. _____

_____

Please attach a current photograph of your child.

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

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 and GRASP to release information to each other in regards to 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: _____

COVID-19 TESTING RELEASE

I give permission for my child to be administered a COVID-19 Rapid Antigen Test if they become symptomatic at the program.

I do_____ I do NOT_____ give permission for my child to be tested. 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

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:

___ESCORTED BY SCHOOL PERSONNEL

MY CHILD WILL DEPART FROM THE PROGRAM:

___PARENT/GUARDIAN OR AUTHORIZED PICK UP

PARENT /GUARDIAN SIGNATURE_____ DATE_____

Commonwealth of Massachusetts
Department of Early Education and Care

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 **no**t 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

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.

Child's Photo

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? **YES** (indicate changes below) **NO** (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 1st.

Pay Monthly Tuition

- Monthly tuition is based upon number of days enrolled

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 1st 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