



Sycamore Services

PATHS Afterschool Application

PROGRAM CHOICES Check the desired sessions

Child Name _____

- Before School Only**
After School Only
Before & After School Only
Before & After School Extended

PAYMENT- AMOUNT AND METHOD

*One time non-refundable registration fee of \$25 per child due with application

Description	Days	1 st Child	Additional Child	Drop-In
Before School Only	4 – 5 Days	\$20 / week	\$20 / week	Each Visit \$12 / child
After School Only	4 – 5 Days	\$30 / week	\$30 / week	Each Visit \$20 / child
Before & After School	4 – 5 Days	\$50 / week	\$45 / week	Each Visit \$32 / child
School Out Days		Add'l \$10 / day	Add'l \$10 / day	Add'l \$10 / child

NOTE: Sycamore Services and the PATHS Afterschool Program will offer any Danville Community Schools Administrator, Teacher, or Staff Member a 25% discount.

*Payment in full *Payment every (2) weeks sessions *Payment once a (1) week sessions

TOTAL PAID \$ _____

Payment method (check one): *Check *Money Order * credit, or debit

Payment Guidelines

Payments must be paid in full for desired program prior to students attending the PATHS Before/After-school Program.

- Checks, money-orders, credit, or debit to:
Children's Services Department
P.O. Box 369
1600 E. Main Street
Danville, IN 46122
- Or with PATHS staff member on-site at any of the Danville Schools that we provide service.

STUDENT INFORMATION

 Please print and complete.

Child Name: _____

Birth Date: _____ Race: _____ Gender: _____

Age on first day of school: _____ Grade in the Fall: _____ School _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

PARENT/GUARDIAN INFORMATION

1. Parent/Guardian Name: _____

2. Parent/Guardian Name: _____

Relationship: Mother Father Legal Guardian Foster Parent

Mail Address: _____

City: _____ State: _____ Zip Code: _____

Place of
Employment: _____

Home Phone: _____ Work
Phone: _____

Cell phone/pager: _____ E-
mail: _____

PROMOTIONAL AGREEMENT (Release of Information)

Sycamore Services does does not have my permission to use photographs of my child in Sycamore Services promotional material, i.e. (brochures, group pictures, flyers)

Parents Signature: _____ Child's Name: _____

STUDENT PICK-UP INFORMATION

I authorize only the people named below to pick up my child unless otherwise noted. For your child's safety, he/she will not be released to anyone else.

All authorized persons must be at least 18 years of age or older. No changes to this list will be made unless the parent or legal guardian whose signature appears below requests such changes in writing.

Photo identification is required at pick up.

Name: _____ Name: _____

Phone: _____ Phone: _____

Other phone: _____ Other phone: _____

Relationship: _____ Relationship: _____

Name: _____ Name: _____

Phone: _____ Phone: _____

Other phone: _____ Other phone: _____

Relationship: _____ Relationship: _____

Parent/Guardian signature: _____

PARENT AUTHORIZATION:

I declare my child to be physically sound, having medical approval to participate in any physical activities. This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed program activities except as noted. I further understand that neither PATHS Before/Afterschool Program nor any of its paid staff can be held responsible in the event of an accident.

STUDENT ACTIVITY AND TRANSPORTATION AUTHORIZATION:

I hereby give permission for my child to participate in activities and to travel by bus with the PATHS Afterschool staff. I understand that only licensed and qualified personnel will operate any vehicle to and from the school campus, and that there will be at least one to two staff members present at all times. I agree to release all Before/Afterschool staff from any and all claims of damages, demands or liabilities which may arise as a result of my child’s participation in activities and bus trips.

EMERGENCY AUTHORIZATION:

I hereby give permission to the medical personnel selected by the Agency director to order X-rays, routine tests and treatment for me or my child, and, in the event I am not able to communicate or cannot be reached in an emergency, I hereby give permission to the physician selected by the Agency director to hospitalize, secure proper treatment for, and order injection(s) and/or anesthesia and/or surgery for me or my child as named above. I will be fully responsible for any costs for such treatment, even if not covered by insurance.

PARENT OR GUARDIAN PERMISSION:

My signature below indicates that I have the legal authority to enroll the child named on this form and that to the best of my knowledge the information on this application is complete and accurate. I further understand that this is an application and the named child participation is contingent upon space being available in the program in which I want the child to participate. I also understand that once my application is confirmed, I must complete payment(s) by the deadlines, and that, furthermore, all necessary health, security and waiver forms must be signed and on file with PATHS prior to my child attending the program. Failure to comply with the above could result in the loss of the before/afterschool space.

SIGNATURE OF PARENT _____ **DATE:** _____

PRINTED NAME _____

Obtain: your 2009-2010 PATHS Application Forms online at www.danville.12.in.us or at Sycamore Services, Inc. Children’s Services Department 1600 E. Main Street- Danville, IN 46122

Submit: your applications by mail to Phyllis Hart- Program Director, P.O. Box 369, Danville, IN 46122 or fax to 317-745-0663

HEALTH INFORMATION

Check all that apply, giving approximate dates, where applicable.

Child Name: _____

Autism ADD/ADHD Frequent ear infection Asthma Bleeding/Clotting Disorders
Convulsions Heart Disease/ Defect Diabetes/Hypertension

Student is up-to-date with all immunizations needed for enrollment in school.

Tetanus. Date: _____

DISEASES (Please Initial)

German Measles _____ Mumps _____ Chicken Pox _____ Hay Fever _____

ALLERGIES

Food _____

Medicine _____

Poison Ivy, etc. _____

Insect Strings _____

Additional Comments

Current medications (send prescription in original bottle): _____

Operations or serious injuries: _____

Disability due to chronic or recurring illness: _____

Any specific activities to be encouraged or limited by physician's advice:

Family physician: _____ Phone: _____

Insurance carrier: _____ Policy # _____

Special needs (physical, mental, or psychological) for staff member awareness:

Diagnosed or Suspected Disabilities: _____