Special Parent Advocacy Group

Child Enrollment Form

Child's Name: _____

Nickname: _____ D.O.B.: _____

Home Address: _____

Primary Phone: _____ Secondary Phone: _____

Father's Name: _____

Address, if different from child: _____

Home Phone: _____ Mobile Phone: _____

Employer: _____ Work Phone: _____

Work Address: _____

Work Schedule: _____

Mother's Name: _____

Address, if different from child: _____

Home Phone: _____ Mobile Phone: _____

Employer: _____ Work Phone: _____

Work Address: _____

Work Schedule: _____

Emergency Contacts:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Doctor/Clinic Information:

Child's Doctor: _____

Name of Clinic: _____

Special Parent Advocacy Group

Address: _____

Phone: _____ Fax: _____

Dentist's Name: _____

Dental Clinic: _____

Address: _____

Phone: _____ Fax: _____

_____ _____

Sign Date

_____

Relationship to Child

**** Do Not Write Under This Line ****

Enrollment Date: _____

Agent: _____ Position: _____

Child Start Date: _____

Attendance Schedule: _____

Special Needs/Instructions: _____

SPAG Transportation: Yes:_____ No:_____ Route: _____

_____ _____

Sign Date

Withdrawal Date: _____

Agent: _____ Position: _____

Last Day: _____

_____ _____

Sign Date

Special Parent Advocacy Group

Family Information

Person(s) Designated to pick up child other than parent(s):

Name:_____ Phone: _____

Name:_____ Phone: _____

Person(s) NOT permitted to pick up child:

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Demographics:

Primary Language spoken at home: _____

List any other children in the family:

Name:_____ Age:_____ Sex: _____

Name:_____ Age:_____ Sex: _____

Name:_____ Age:_____ Sex: _____

Name:_____ Age:_____ Sex: _____

Name:_____ Age:_____ Sex: _____

List other adults living in the home:

Name:_____ Relationship to child: _____

Name:_____ Relationship to child: _____

Name:_____ Relationship to child: _____

List any pets in the home and their names, including therapy pets: _____

_____

List previous experience in day care, including the name of facility, dates attended and type of care provided (such as family day care, day care center, nursery school, nanny):

_____

_____

Special Parent Advocacy Group

Medical Declaration Statement for School-Aged Child Care

Child's Full Name: _____

Date of Birth: _____ Grade: _____

Child's Official Diagnosis: _____

Age when diagnosed: _____

Is your child under any medical/physical restrictions? Yes _____ No _____

If yes, check all that apply:

_____ Asthma _____ Diabetes _____ Convulsions/Seizures _____ Hearing Loss

_____ Heart Condition _____ Liver Disease _____ High Blood Pressure _____ Heart Disease

Other (please be specific): _____

Is your child taking medication? Yes _____ No _____

If yes, please list all medications and dosages: _____

_____

_____

Has your child been under a doctor's care or hospitalized within in the last 3 years?

Yes _____ No _____

If yes, please explain: _____

_____

_____

Is your child up to date on immunizations? Yes _____ No _____

If not, please explain why: _____

_____

Special Parent Advocacy Group

Is your child allergic to any medications, foods, insect bites, or anything that may not have been mentioned? Yes_____No _____

If yes, please explain: _____

_____

_____

Physician's Name:_____Phone: _____

Address: _____

As the parent/guardian of the above-mentioned child who will be attending this program, I certify that he/she is in good physical health and may participate in all of the activities of the Family Child Care Program as designated by Special Parent Advocacy Group, except as noted above.

_____ _____

Sign Date

_____

Print Name

Special Parent Advocacy Group

Emergency Treatment Information and Authorization

I (name of parent/guardian)_____do hereby agree to the administration of emergency medical treatment to my child (name of child) _____, date of birth_____, by a duly qualified health practitioner in my absence. I authorize (name of provider/organization) _____ to arrange for such emergency treatments until such time as I can be present.

_____ _____

Sign Date

_____

Print Name

What (if any) illness(es) has your child had in the past month? _____

What is your child's disability/diagnosis? _____

Is your child now taking any type of medication? _____

If yes, please explain: _____

_____

_____

Is your child allergic to any medications, foods, insect bites, or anything that may not have been mentioned? _____

If yes, please explain: _____

_____

_____

Special Parent Advocacy Group

Please list any chronic health problems or handicaps your child has, such as seizures, asthma, diabetes, heart disease, respiratory illness, high blood pressure:

_____

_____

_____

Parent's hospitalization insurance or medical assistance plan:

Name of Insurance/Company: _____

Identification Number: _____

Policy is in name of: _____

Customer Service Phone Number: _____

Special Parent Advocacy Group

Personal Information Record for School-Aged Children

Child's Name:_____ Age: _____

1. What does your child usually prefer to do after arriving home from school?

_____

_____

_____

2. What is your child's favorite snacks?

_____

_____

_____

3A. Does your child have a strong dislike for certain foods? _____

If so, what? _____

3B. Are there any foods your child is not permitted to eat? _____

If so, please explain: _____

_____

_____

4. Do you wish to have your child complete homework assignments while in after school respite? _____

5. Would you prefer to balance some active play with completing homework assignments? _____

6. Are there any activities that you DO NOT want your child to participate in?

_____ If so, please explain: _____

_____

Special Parent Advocacy Group

7. List the person(s), including yourself, permitted to pick child up from the After School Program:

Name: _____

Name: _____

Name: _____

Name: _____

8. Is your child permitted to watch limited television while at After School? Yes_____No _____

If so, what television program would you recommend? _____

_____

9. What are your child's hobbies/interests? _____

_____

_____

10. Is there any additional information you'd like to add? _____

_____

_____

Child's School and Grade: _____

Teacher's Name:_____Phone: _____

_____ _____

Parent Sign Date

_____

Print Name

_____ _____

SPAG Agent Sign Date

_____

Print Name

Special Parent Advocacy Group

Authorization to Leave the Premises

I, (name of parent/guardian) _____
will hereby permit my child _____
to leave the site of Special Parent Advocacy Group Respite Programs on predesignated dates as indicated on Respite Calendar(s) for the following purposes:

- Field Trips/Outings
- Walks
- Other outdoor activities

As well as in the case of an emergency, or for the purpose of transporting my child home after the program.

_____ _____

Sign Date

_____

Print Name

Special Parent Advocacy Group

Permission to Use Sunscreen

My child, _____ may have sunscreen applied to exposed skin/areas before going outside on warm, sunny days.

I, (name of parent/guardian)_____will provide sunscreen with a sun protection factor (SPF) of 15 or more; without Paba as per SPAG's recommendation. Paba gives some children blotchy rashes.

I will also make my child's name of his/her sunscreen PLASTIC container with a permanent marker and keep it in my child's bag at the facility.

_____ _____

Sign Date

_____

Print Name

Special Parent Advocacy Group

Permission to Photograph/Video Record

I, (name of parent/guardian)_____, do hereby give permission to Special Parent Advocacy Group to photograph or video record my child, (name of child) _____ for the purpose of advertisements, newspaper articles, blog posts and social media networking to strictly be used for business purposes.

I understand that my child may be included in group pictures and videos as well as individual ones that might be posted on the internet or in-print publications. I also understand that I have the right to request copies of said imagery at no additional charge to me.

_____ _____

Sign Date

_____

Print Name

Authorization to Bill CSOC/DDD

Client: _____ Guardian (if Minor): _____

Phone: _____ Email: _____

Address: _____

I, the undersigned, hereby certify and attest that I have enrolled my child in programming with Special Parent Advocacy Group and I give permission for services to be billed to CSOC/DDD.

I understand and acknowledge that the SPAG billing staff will submit my claim to CSOC/DDD via Molina on my behalf. I further understand that I will be held responsible for paying all late fees as it results to late pick up at $1.00 per minute.

I understand that any portion of respite services not covered by CSOC/DDD will be billed to me at the address I have provided above. Non-compliance or defaulting on payments may result in denial of service and/or a legal claim against me for non-payment.

_____ _____

Signature Date

Special Parent Advocacy Group

Respite Service Plan (Annual Plan)

(simple statement that gives the purpose of the service and the goals)

Parent's Name	Parent's Signature	Date

Enrollment Coordinator Name	Signature	Date

Student Emergency Contact Form

Personal Information

First Name _____ Last Name _____

Student ID# _____

Home Address _____

Address (Line 2) _____

City _____

State _____ ZIP Code _____

Home Phone _____ Cell Phone _____

E-mail _____ Date of Birth _____

Emergency Contact

First Name _____ Last Name _____

Relationship _____

Home Phone _____ Cell Phone _____

Work Phone _____ E-mail _____

Secondary Emergency Contact-(if 1st Emergency Contact is not local)

First Name _____ Last Name _____

Relationship _____

Home Phone _____ Cell Phone _____

Work Phone _____ E-mail _____

Additional Information _____

No one can make the decision about electing group respite services but the parent or guardian (and the youth if over 18). After reviewing this document, consideration of risks related to COVID-19, and discussing specific questions and concerns you may have with the group respite services provider, parents or guardians should advise the group respite provider if they will be electing group respite services.

When group respite services reopen, what is the plan to transport the youth to and from the program?

☐ The youth will need transportation to and from the program. The family and guardian understand that the challenge of social distancing during transportation may impact access to group respite services.

☐ The parent or guardian is willing to provide transportation to the program for the youth.

Person Completing this Form (Print): _____

Signature: _____

Date: _____

NEW JERSEY DEPARTMENT OF CHILDREN AND FAMILIES

Agency Afterschool Respite and Agency Weekend Recreation
Receipt of COVID-19 Information Form
October 21, 2020

The Centers for Disease Control and Prevention[1] [2] (CDC) maintains a website to provide information about COVID-19. Families, guardians, providers and other stakeholders are encouraged to review the CDC links below for more information as they continue to be updated. Currently, the CDC website provides the following information:

How COVID-19 is thought to spread

- Mainly person to person, through respiratory droplets produced when infected persons cough, sneeze, or talk.
- These droplets can land in mouths or noses of people who are nearby or possibly be inhaled into the lungs.
- Spread is more likely when people are in close contact with one another (within about 6 feet).
- It may be possible that people can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes.

Those at risk of exposure

Everyone, regardless of disability, is at risk for being exposed to COVID-19 and getting sick. Certain populations, including those who are older or have underlying medical conditions are more likely to become severely ill, which means that they may require hospitalization, intensive care, a ventilator to help them breathe, or may even die.

People with the below medical conditions **are at an increased risk** for severe illness at any age:

- Cancer;
- Chronic kidney disease;
- COPD (chronic obstructive pulmonary disease);
- Immunocompromised state (weakened immune system) from solid organ transplant;
- Obesity (body mass index [BMI] of 30 or higher);
- Serious heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies;
- Sickle cell disease;
- Type 2 diabetes mellitus.

Based on the information available at this time, people with the following conditions **might be at an increased risk** for severe illness from COVID-19:

- Asthma (moderate to severe);
- Cerebrovascular disease;
- Cystic fibrosis;
- Hypertension or high blood pressure;
- Liver disease;
- Neurologic conditions, such as dementia;
- Pregnancy;
- Pulmonary fibrosis (damaged/scarred lung tissues);
- Smoking;
- Thalassemia (a type of blood disorder);
- Type 1 diabetes mellitus.

[1] www.cdc.gov/coronavirus/2019-ncov/faq.html

[2] https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-increased-risk.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fneed-extra-precautions%2Fpeople-at-higher-risk.html

- Immunocompromised state (weakened immune system) from blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, or use of other immune weakening medicines;

Per the CDC, certain disability groups might be at an increased risk of becoming infected.

- People who have limited mobility or cannot avoid close contact with others who may be infected;
- People who have trouble understanding information or practicing measures like hand washing & social distancing;
- People who may not be able to communicate symptoms of illness.

How to reduce the risk of getting COVID-19

It is especially important for people at increased risk of severe illness from COVID-19, and those who live with them, to protect themselves from getting the virus. The best way for someone to protect themselves and help reduce the spread of COVID-19 is to:

- Limit your interactions with other people as much as possible;
- Take precautions to prevent getting COVID-19 when there is interaction with others;
- Wear face coverings.

Face coverings are a critical preventive measure and should be worn in public settings and when around people who don't live in the same household. They are **most** essential when social distancing is difficult. If an individual does not tolerate a face covering or it is not medically advisable to wear one, measures to reduce the risk of COVID-19 spread must occur, including social distancing, frequent hand washing, and cleaning and disinfecting frequently touched surfaces[3].

Your service provider is taking precautions to lower the risk of transmission of COVID-19, but cannot entirely eliminate any risk. Your provider can relay what precautions they are taking to lower the risk of transmission. Department of Children and Families policies related to COVID-19 can be found at https://www.nj.gov/dcf/coronavirus.html. Parents and guardians are encouraged to consider risks and talk with program staff about screening and prevention strategies that may be used.

If you or someone you know has questions about COVID-19 risk, it is recommended that you consult your health care provider or contact the New Jersey Department of Health either by visiting their COVID Information Hub at https://covid19.nj.gov/ or by calling 1-800-962-1253.

By signing this document, the youth's parent or guardian (and the youth if over 18) acknowledges receipt of this information and will consider it in their decision to elect Agency Afterschool Respite and Agency Weekend Recreation. Electronic signatures are acceptable.

Name of Youth (Please Print):

CYBER Number:[4]

Name of Parent or Guardian: (Please Print):

Signature of Parent or Guardian: _____

Date: _____

Signature of Youth age 18 or older: _____

Date: _____

[3] https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover-guidance.html

[4] Service providers can provide the CYBER Number if you do not have it

Consumer Personal Property Policy

Consumers are not to bring ANY Personal Property into the program. The only exception to this is lunch for outings and medication that we already have a script for. All other items are to be left at home. If you still choose to send any personal items, we will not be responsible for it. Any other individual property brought into the program, will not be the responsibility of Special Parent Advocacy Program (SPAG). These items include but are not limited to: Cell phones, iPad, and toys. We are NOT responsible for items being lost, stolen, broken or damaged in anyway.

Any violations of this policy can/will result and suspension from the program.

Your lack of signature does not reverse this policy.

Parent Signature _____

Thank you for your cooperation.