Suffolk Department of Parks and Recreation
Kid Zone 2021-2022 Before/After-School Program Registration

Note: Registration is not complete and seat is not held until payment is made

Site: ☐ BTWRC ☐ CRC ☐ MBRC ☐ NSRC ☐ ORC

PROGRAM(S): ☐ BEFORE CARE ☐ AFTER CARE ☐ BEFORE & AFTER CARE

Child's Name:		Nickname:
Sex:	Age:	Date of Birth:
Address:		
City:	Zip:	Home Phone:
School:		Grade: Teacher:
Mother's Name:		Place of Employment:
Work Phone:		Cell Phone:
Father's Name:		Place of Employment:
Work Phone:		Cell Phone:
Mother's Email:		Father's Email:

Person(s) authorized to pick up child:
Person(s) **NOT** authorized to pick up child: (legal documentation must be attached if a parent is listed here)

EMERGENCY CONTACTS:

List two people who **DO NOT** live at the same address or have the same phone number as the parent/guardian

Name:		Relationship:
Address:		
Home Phone:	Work Phone:	Cell Phone:
Name:		Relationship:
Address:		
Home Phone:	Work Phone:	Cell Phone:

Medical Information

Suffolk Department of Parks and Recreation takes pride in providing inclusive recreational opportunities for all. In order to best serve and meet the needs of each participant, please provide any special needs, disabilities or accommodations so that our team can provide successful participation within our programs.

Primary Diagnosis/Condition:_____

Special needs and Accommodations: _____

Level of Severity or Disability: □ Mild □ Moderate □ Severe

└> Comments:

Participant primarily uses/requires (please explain):

□ Special Assistance -

□ Assistive Technology -

□ Accessibility Equipment-

└> Wheelchair (if applicable): □ Manual Wheelchair □ Power Wheelchair □ Walker

□ Other -

*For programs and events that require specific participant accommodations and special needs, advance registration and assessment is required from our Certified Therapeutic Recreation Specialist.

EMERGENCY INFORMATION:	
List any medical condition or allergies your child may have and any prescription drugs your child may be taking: (Reminder – staff cannot store or administer medication) List <u>all</u> critical and pertinent information which will help staff to better accommodate and understand your child: (death in family, adoption, depression, hyperactivity, foster care etc.)	
Family Physician:	**Phone:**

Please read and affirm the following with your initials:

_____ I give permission for my child to attend the field trips during Kid Zone program hours. I understand my child will be riding a Suffolk Public School bus. I realize that departure and return times are approximate. I understand that the recreation center will be closed on field trip days and I will need to make other arrangements if my child will not be attending the trip.

_____ I understand that my child must be signed in upon arrival and signed out upon departure each day.

_____ I understand that the program closes at 6:00 p.m. and if my child is not picked up by this time I owe a late fee of $1 for every minute after 6:00 p.m. I also understand my child may not return to the program until said fee is paid in full. I understand the staff will go by the center clock and no other. I am also aware that three (3) late pick-ups will result in my child's expulsion from the program.

_____ I understand that if I do not make payments on or before the due date, my child's space will be offered to the next person on the waiting list or to the next person interested in registering if no waiting list exists. I also understand there are **no refunds, no exceptions**. I have read and understand the information listed in the parent information guide, and recognize that I am responsible for the information contained in it.

_____ In the event of an emergency, I give permission for my child to be transported to the nearest medical facility and have appropriate care administered. It is understood that the staff will make every effort to contact you in such instances.

_____ I will pick up my child immediately or make arrangements for my child to be picked up immediately if he/she becomes ill or is having behavior issues.

_____ I consent to my child being photographed or videoed during this program; and I understand that these photos can be used for publication to promote the Department's events, activities and programs.

_____ I will not hold the City of Suffolk Department of Parks and Recreation, its staff or representatives responsible for loss of personal property or for medical or dental expenses incurred as a result of said participation; including liabilities, expenses or judgments, attorney's fees, or court costs, except claims caused by the gross negligence or willful misconduct of the department.

<u>Release and Waiver:</u> In consideration of being permitted to participate in any way in the <u>Kid Zone Before and After School Program</u>, I for myself, my heirs, personal representatives or assigns, do hereby release, waive, and forever discharge the City of Suffolk, its Council members, officers, employees, and agents for liability from any and all claims, demands, rights and causes of action of whatever kind resulting in, but not limited to, bodily injury, personal injury, accident or illness (including death), and property damage sustained by me and my agents, representatives, employees, or family members arising from participation in the <u>Kid Zone Before and After School Program.</u>

<u>Indemnification</u>: I shall indemnify and hold harmless the City of Suffolk, its Council members, officers, employees, and agents from and against any and all claims, losses, damages, fines, penalties, suits and costs, including injury and death penalties imposed by any authority which arise out of any violation of law by, and all acts and omissions caused by me, my employees, subcontractors, agents, or representatives during the participation in the <u>Kid Zone Before and After School Program</u>.

Parent Guardian Printed Name: _____

Signature of Parent/Guardian: _____

Date Signed: _____ (If transcribed, staff initial here_____)

OFFICE USE ONLY		
Item	*Description*	*Staff Initials*
Proof of Grade		
Proof of Residency		
Proof of Kindergarten (if applicable)		

Payment Information:					
Date	Amount	Check/MO #	Receipt #	Month(s) Paid For	Staff Initials