



SCHOOL KIDS CAMP INFORMATION SHEET

In response to school closings in our community Southeast Health and the Southeast Health Foundation will implement school-age child watch services. Please complete the application in full to participate in the School Kids Camp during the COVID-19 pandemic. You can then email the application to schoolkidscamp@southeasthealth.org or drop-off at the Southeast Health Foundation building by the Friday prior to the coming week to secure placement for your child.

Because social distancing is an important strategy to stop the spread of COVID-19, we strongly encourage parents to use this service after all other options have been considered.

- » **Proof of Vaccination will be required at registration.**
- » CDC guidelines will be followed for social distancing, hand-washing, and other recommendations.
- » Children will be screened for symptoms at check-in. If child has a fever of 99.7 or higher, flu-like symptoms, or has been in contact with someone who has COVID-19 then alternate childcare should be sought.
- » Allow 10-15 minutes in your schedule for check-in each day.
- » We are not responsible for administering medications.
- » I.D. will be required for check-out each day.
- » Person picking child up **MUST** be listed on application form. If they are not, a parent or guardian must notify staff in writing and an I.D. will be required at pick-up.
- » Food will be provided for breakfast, lunch, dinner, and snacks. If your child has a special diet, please provide a meal/snacks for your child
- » Personal electronics will be allowed. Please put name on all personal belongings. We will make all efforts to protect personal belongings, but we are not responsible for loss or damage.

CAMP LOCATION:

**Wiregrass Church
900 West Main Street
Dothan, Alabama**

CONTACT:

**Southeast Health Foundation
334- 673-4150**

PLEASE NOTE:

This childcare service is a program provided solely by Southeast Health. Wiregrass Church is only providing the facilities and Southeast Health assumes all responsibilities of the program.

YOU MUST COMPLETE THE APPLICATION ON THE FOLLOWING PAGES →

ENROLLMENT APPLICATION

Child's full name

Date of birth

Name known by

Age

MOTHER'S INFO:

Mother's name

Address

City / State / Zip

Home phone

Work phone

Cell phone

Pager

Email address

Employer

Southeast Health Department (if applicable)

FATHER'S INFO:

Father's name

Address

City / State / Zip

Home phone

Work phone

Cell phone

Pager

Email address

Employer

Southeast Health Department (if applicable)

WHOM TO CALL IN AN EMERGENCY IF PARENTS CANNOT BE REACHED:

Name

Work phone

Address / City / State / Zip

Home phone

Relationship to child

CHILD'S DOCTOR

Name

Phone

CHILD MAY BE RELEASED TO (OTHER THAN PARENTS LISTED ABOVE):

Name

Relationship

Name

Relationship

Name

Relationship

Name

Relationship

PARENT / GUARDIAN SIGNATURE

DATE

Child's full name _____

Date of birth _____

FOOD ALLERGIES OR RESTRICTIONS: _____

MEDICATION ALLERGIES OR RESTRICTIONS: _____

EXISTING ILLNESSES: _____

PREVIOUS SERIOUS ILLNESS OR INJURY: _____

MEDICATION PRESENTLY BEING ADMINISTERED: _____

IS YOUR CHILD CURRENT ON ALL RECOMMENDED VACCINATIONS? Yes No

PROOF OF VACCINATIONS WILL BE REQUIRED AT REGISTRATION.

HAS YOUR CHILD HAD ANY OF THE FOLLOWING DISEASES?

- | | | | |
|--------------------------------------|--|--|---|
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Measles | <input type="checkbox"/> Ear Tubes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Speech Problems | <input type="checkbox"/> Chronic Ear Infections |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Other: _____ | | |

PARENT / GUARDIAN SIGNATURE

DATE

Child's full name

_____-_____-_____
Date of birth

EMERGENCY MEDICAL TREATMENT

Should my above-named child's condition worsen or should (s)he become ill or suffer an accident while in the care of Southeast Health, I hereby authorize SOUTHEAST HEALTH to seek and obtain such medical attention, treatment and services for my child as may be deemed necessary. If my child must be transported to a physician's office or a hospital emergency department in order to obtain needed medical treatment, I hereby authorize such transport and do agree to release SOUTHEAST HEALTH and its staff from any claims as a result of such transport. I agree to assume all medical costs.

ALLERGIES: _____

HEALTH & ACCIDENT INSURANCE: _____

HEALTH & ACCIDENT INSURANCE POLICY #: _____

PARENT / GUARDIAN SIGNATURE

DATE

ARRIVAL AND DEPARTURE

I, or someone authorized by me will bring my above-named child to Wiregrass Church. My child will be picked up each day by myself or a person I designate. I will be responsible for getting him/her to the assigned staff each day and will sign him/her out when picked up.

PARENT / GUARDIAN SIGNATURE

DATE

WEEKLY SCHEDULE

Please provide the days and times you will need childcare. Childcare will be available Monday-Friday 6 a.m. – 8 p.m.

Child's full name

_____-_____-_____
Date of birth

DATE OF THE WEEK REQUESTED _____

Example: March 23 – March 27

	DROP OFF TIME	PICK UP TIME
MONDAY	_____	_____
TUESDAY	_____	_____
WEDNESDAY	_____	_____
THURSDAY	_____	_____
FRIDAY	_____	_____