CHILD NAME:_____ BIRTHDAY:_____

All fields must be completed for registration packet to be considered complete.

Parent Information Page

The 180 Center After School Care
2021-2022 School Year

The 180 Center After School Program is more than a place for children to go afterschool. It's a place where caring adults deliver a quality program focused on safety, health, social growth, and academic support so children grow and thrive in our care.

In our care, your child will receive:

- 60 minutes of physical activity
- Homework assistance
- Curriculum focused on building leadership skills and values
- Attend Lessons Offered in the facility

Tuition Rates

Your monthly tuition rates are based on the number of days school is in session and averaged over the 10 months of the school year, this ensures a consistent monthly fee. Monthly program fees are not adjusted for break weeks (i.e. winter, spring, summer breaks or shorter months) or inclement weather days (i.e. snow days, late starts).

Additional Fees

Care for the times listed below are only available to current members and participants of The 180 Center After school Program.

Break Weeks
Winter, Mid-Winter, Spring, and Summer Breaks: Break Week Camps may be offered at select sites for an additional fee. Please, contact your Program Director for more information
National Holidays
National Holidays: The 180 Center After School Program is closed and not provided for national holidays.
Transportation
Transportation Fee: If your child attends a school requiring transportation to the care site, a transportation fee may apply.

Vacation

Two weeks of vacation credit is available with a required two weeks advanced written notice.
Requests must be approved by program director and cannot coincide with break weeks and two weeks before draft date.

Withdrawal of Care

Parent/Guardians must provide a two-week advance written request for refunds due to vacation, cancellation, schedule change, or account information change. The 180 Center Child Care does not provide refunds if your child is suspended for any reason. Written notices can be given to site staff or emailed to the business office.

CHILD NAME:_____ BIRTHDAY:_____

All fields must be completed for registration packet to be considered complete.

The 180 Center Child Care Registration

2021-2022 School Year

GENERAL INFORMATION		
CHILD'S FIRST NAME	**CHILD'S LAST NAME**	**FIRST DAY OF CARE (DATE):**
SCHOOL THAT CHILD WILL ATTEND IN 2021-2022		
NAME OF SCHOOL		

MONTHLY FEES AFTER SCHOOL CARE (CLOSE 6:00pm)	
DROP OFF AT FACILITY (M-F)	**BUS PICK UP FROM SCHOOL (M-F)**
☐ **$55 per week**	☐ **$ 65 per week**
-$220 per month	**-$260 per month**
M-F 3:30pm-6:00pm	**M-F 3:30pm-6:00pm**
REGISTRATION FEE	
$75 Registration fee per family	

To Register:

- ☐ **Fill out registration packet completely. Incomplete registration forms will not be accepted.**
- ☐ **Return to The 180 Center After School Care**
  586 Hentz RD
  Pope, MS 38658
  Scan and Email: the180center.ms@gmail.com

OFFICE USE ONLY		
DATE ACCEPTED	BY: STAFF NAME	MEMBER #
APPROVED BY DIRECTOR _____YES _____ NO	PROGRAM DIRECTOR NAME	DATE APPROVED

CHILD NAME:_____ BIRTHDAY:_____

All fields must be completed for registration packet to be considered complete.

PARENT/GUARDIAN INFORMATION

PARENT/GUARDIAN FULL NAME		**AUTHORIZED TO PICK UP CHILD?** **YES_____ NO_____**
PHYSICAL ADDRESS (no PO Box)	**CITY**	**ZIP CODE**
MAILING ADDRESS	**CITY**	**ZIP CODE**
HOME PHONE NUMBER	**CELL PHONE NUMBER**	**WORK PHONE NUMBER**
EMAIL	**RELATIONSHIP TO CHILD**	

PARENT/GUARDIAN FULL NAME		**AUTHORIZED TO PICK UP CHILD?** **YES_____ NO_____**
PHYSICAL ADDRESS (no PO Box)	**CITY**	**ZIP CODE**
MAILING ADDRESS	**CITY**	**ZIP CODE**
HOME PHONE NUMBER	**CELL PHONE NUMBER**	**WORK PHONE NUMBER**
EMAIL	**RELATIONSHIP TO CHILD**	

WHO DOES THE CHILD LIVE WITH? (SELECT ALL THAT APPLY)

_____MOM _____DAD _____STEPPARENT _____GRANDPARENT(S) _____ GUARDIAN _____ OTHER

IF APPLICABLE, WHO IS CUSTODIAL PARENT/GUARDIAN?

IF APPLICABLE, WHO IS NO AUTHORIZED TP PICK UP CHILD? (Must provide legal documentation with Registration Packet)

EMERGENCY CONTACTS (Local contacts only, must be different than parent/guardian listed above. Minimum of three emergency contacts required. Child will not be released unless they are listed below. Contacts must be at least 14 years old and must be able to provide photo identification.)

EMERGENCY CONTACT FULL NAME	**RELATIONSHIP TO CHILD**	
PHYSICAL ADDRESS (no PO Box)	**CITY**	**ZIP CODE**
CONTACT PHONE NUMBER	**AUTHORIZED TO PICK UP CHILD?** **YES___________ NO_______________**	

EMERGENCY CONTACT FULL NAME	**RELATIONSHIP TO CHILD**	
PHYSICAL ADDRESS (no PO Box)	**CITY**	**ZIP CODE**
CONTACT PHONE NUMBER	**AUTHORIZED TO PICK UP CHILD?** **YES___________ NO_______________**	

EMERGENCY CONTACT FULL NAME	**RELATIONSHIP TO CHILD**	
PHYSICAL ADDRESS (no PO Box)	**CITY**	**ZIP CODE**
CONTACT PHONE NUMBER	**AUTHORIZED TO PICK UP CHILD?** **YES___________ NO_______________**	

EMERGENCY CONTACT FULL NAME	**RELATIONSHIP TO CHILD**	
PHYSICAL ADDRESS (no PO Box)	**CITY**	**ZIP CODE**
CONTACT PHONE NUMBER	**AUTHORIZED TO PICK UP CHILD?** **YES___________ NO_______________**	

CHILD'S INFORMATION (One form per child)

CHILD'S FIRST NAME		CHILD'S LAST NAME		
DATE OF BIRTH		AGE	GRADE	GENDER M_____ F_____
HEIGHT	WEIGHT	EYE COLOR	HAIR COLOR	
OPPERATIONS/CHRONIC ILLNESS				
DATE OF LATE PHYSICAL EXAM		DATE OF LAST DENTAL EXAM		

ALLERGIES TO FOOD OR DRUGS

_____NO _____ YES: List allergies and fill out Individual Care Plan form found at site with any necessary medical info.

PHYSICAL, EMOTIONAL, PSYCHOLOGICAL, OR BEHAVIORAL NEEDS/ CONSIDERATIONS

_____NO _____ YES: List need/considerations along with any other necessary medical info.

DOES YOUR CHILD TAKE ANY MEDICATION ON A REGULAR BASIS?

_____NO _____ YES: List medications and dosages

WILL STAFF NEED TO ADMINISTER AND MEDICATION DAILY?

_____NO _____ YES: Fill out medical authorization form and turn in with medication in original prescription container

CHILD NAME:_____ BIRTHDAY:_____

All fields must be completed for registration packet to be considered complete.

MEDICAL CONTACT INFORMATION

(If child has no medical or dental provider, parent/guardian must provide a written plan for medical or dental injury or incident.)

FAMILY DENTIST		PRIMARY PHONE NUMBER
ADDRESS	**CITY**	**ZIP CODE**

FAMILY PHYSICAIN		PRIMARY PHONE NUMBER
ADDRESS	**CITY**	**ZIP CODE**

HOSPITAL OF CHOICE		PRIMARY PHONE NUMBER
ADDRESS	**CITY**	**ZIP CODE**

INSURANCE COMPANY		PRIMARY PHONE NUMBER
POLICY HOLDER	**POLICY NUMBER**	

CHILD NAME:_____ BIRTHDAY:_____

All fields must be completed for registration packet to be considered complete.

Form No. 121 Certificate of Immunization Compliance

Name of Child/Student/Employee _____

Birthdate _____

Name of Parent:_____

Address_____

Vaccine	Date Each Dose Was Given				
	1st	2nd	3rd	4th	5th
Pneumococcal					
Varicella					
DTaP/DT/Td					
Hib					
Polio					
MMR					
Hep B					
Tdap					
Other					

□ Check here if prior history of chicken pox □ Medical Exemption Form 122 attached

The individual named above has met the immunization requirements for attendance or employment in a Mississippi child care facility or entry into a Mississippi public or private school, college, or university.

Please check one box only

□ Complete Until School Entry

□ Complete for school entry (K4-6th grade)

□ Complete for middle school, high school, university/college, work requirements (7th grade and above)

□ **Temporarily compliant-next immunization is due _____/_____/_____** ***Month Day Year***

□ Record in transit, valid until _____/_____/_____ *Month Day Year*

Date of serological confirmation of immunity *Varicella _____ / _____ / _____

Month Day Year

*Measles _____ / _____ / _____

Month Day Year

*Rubella _____ / _____ / _____

Month Day Year

*Mumps _____ / _____ / _____

Month Day Year

Serological testing for the above are the only acceptable titers that will be allowed for child care and school entry for those who are not fully immunized.

_____
_____ _____/_____/_____

Print or Stamp Name of Facility Signature and Title of Issuing Individual Month Day Year

Hib and Pneumococcal vaccines are only required for child care.

MISSISSIPPI STATE DEPARTMENT OF HEALTH Revised 5/17/12 Form No. 121E

CHILD NAME:_____ BIRTHDAY:_____

All fields must be completed for registration packet to be considered complete.

PARENT/GUARDIAN GUIDE ACKNOWLEDGEMENT

READ AND INITIAL EAACH STATEMENT	
	I understand that I can find the Parent/Guardian Guide at The 180 Center or online at the180.center and I am responsible for reading it
	I am requesting a hard copy of the Parent/Guardian Guide (you do not need to initial if you do not need or want a hard copy).
	I recognize participants are expected to follow all safety instructions, remain in areas designated by staff, and refrain from behavior harmful to oneself or others. I understand that failure to adhere to program and behavior policies could be cause for participant's dismissal without refund of program fees. Please refer to Parent/Guardian Guide for clarification.

STATEMENT OF UNDERSTANDING, PERMISION AND COMPLIANCE

READ AND INITIAL EACH STATEMENT	
	My child has permission to participate in school-based activities and assistance as requested by teacher or designated personnel.
	Staff have permission to administer hand sanitizer to participants.
	I am aware and I approve of my child having an opportunity to participate in program activities which may involve a degree of risk and I hereby release The 180 Center from any and all responsibility and liability of any nature resulting from my child's participation in The 180 Center activities and transportation as required.
	In the event that my child is injured, I give The 180 Center first-aid and CPR-certified staff the authority to provide basic first-aid and CPR as the situation requires, and/or if they become seriously ill or injured and I cannot be reached.
	I authorize any emergency transportation, hospitalization, x-ray, medical, dental, and/or emergency surgical treatment advisable by the circumstances by any member of the medical staff of the medical facility.
	I grant permission for photographs/videos which include my child to be used at his or her site for safety reasons (visual displays, photo albums, and art projects. These photos will stay at the site only.
	I grant permission for photographs/videos which include my child in The 180 Center records, program projects, marketing, and public relations to be used in media releases and social media to benefit the program.
	I understand if I did not provide medical and/or dental care provider names and contact information, I must provide a written plan for medical or dental injury or incident.
	I understand I can request a health care plan that includes the child care disaster plan, from the business office and am responsible for reading it.
With my signature below, I agree to the policies outlined in this form and the Parent Guide information, including inclement weather policies and cancellations due to unpaid tuition, behavior, and the refund policies.	

CHILD NAME:_____ BIRTHDAY:_____

All fields must be completed for registration packet to be considered complete.

PARENT/GUARDIAN	DATE

PAYMENT POLICIES AND PROCEDURES

ANNUAL HOUSEHOLD INCOME (Please select from the choices below)

___Less than $15, 000 ___ Less than $30,000 ___ Less than $45,000 ___Less than $60,000 ___More than $60,000

CHILS'S ETHNICITY/RACE

___Asian/Pacific Islander ___Native American ___African-American ___Hispanic ___Caucasian ___Other _____

MILITARY INFORMATION

Is your child a military dependent? Yes____ NO____

Do you have a military affiliation? ___Active-Duty Military ____Retired/Veteran ___No military affiliation

Branch of Military: ___N/A ___Army ___Air Force ___Navy ___ Marines ___Coast Guard ___National Guard

___ DOD Civilian

CHILD IS A FIRST TIME 180 CENTER PARTICIPANT _____YES _____NO

HOW DID YOU HEAR ABOUT THE PROGRAM? (Check all that apply)

___Facebook ____180 Center Child Care Participant ___Hosanna Church Member ____ Friend ____Website

___ Other

PRIMARY PERSON RESPONSIBLE FOR PAYMENTS

Name (First)_____ (Last)_____

SECONDARY PERSON RESPONSIBLE FOR PAYMENTS (Additional form required with account information)

Name (First)_____ (Last)_____

PAYMENT METHOD (Please select from choices below)

___I choose to auto draft with bank account, including first month's payment and registration fee (attach a voided check)

Bank Name_____ Account Holder Name_____

Routing Number_____ Account Number_____

Draft Date: _____1st _____15th

_____I choose to auto draft with credit card or debit card

_____ Visa _____MasterCard _____ American Express _____Discover

Name on Card_____ Expiration Date_____

Card Number _____ Verification Date_____

___I choose not to auto draft. I understand my payment is expected by the 5th of every month or I am responsible for a late fee of $25 and a suspension of care will apply if my payment is late.	
STATEMENT OF UNDERSTANDING (read and initial statements below)	
	I understand and have read all payment policies and procedures, chosen my payment method, and agree to abide by all policies in place. I understand failure to uphold my payment arrangements will result in a $25 late fee as well as a suspension from the program.
	I understand that I must provide a two-week advance written request for refunds due to vacation, cancellation, schedule change, or account information change. I understand that The 180 Center Child Care does not provide refunds if my child is suspended for any reason.
	I have included all information as requested above, and if there is a secondary responsible party, it is my responsibility to have this form duplicated and submitted to that party for their acceptance of payment policies and procedures. I understand the late payment policy is enforced regardless of who is responsible for the late payment.
	I authorize an Automatic Transfer System (ATS) payment each month from the specified checking account or debit/credit card for all monthly child care payments to include drop in care or additional coverage as requested by myself.

Signature_____ Date_____