

## **CAMS Aftercare**

**2019-20**

### **Location**

AW Spalding - Students will sign out as walkers from CAMS and then walk down to AWS checking in by 3:30 at the front desk.

### **Hours and Rates**

Monday – Thursday: 3:30-6:00

Friday: 2:30-4:00

\$140 monthly rate 10% discount for multiple children

\$20 drop-in rate

\$1 late fee per minute

The application can be found on our website.

If you have any questions feel free to give us a call. 423-396-3020

**Hours of Operation: Mon-Thurs: 3:00 – 6:00pm /Friday: 2:30 – 4:00**

### **Rates:**

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- \$20 drop in rate
- \$1.00 Per Minute Late Fee

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2018-19

**Hours of Operation: Mon-Thurs: 3:00 – 6:00pm /Friday: 2:30 – 4:00**

**Rates:**

- \$140 monthly rate
- \$20 drop in rate
- \$1.00 Per Minute Late Fee

**Child's Name:** \_\_\_\_\_ **Date of Enrollment:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Grade:** \_\_\_\_\_

***Emergency Information***

**Mother's Name:** \_\_\_\_\_ **Address:** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Cell:** \_\_\_\_\_  
**Father's Name:** \_\_\_\_\_ **Address:** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Cell:** \_\_\_\_\_

**Person(s) Responsible for Child:**

\_\_\_\_\_

**Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Address:** \_\_\_\_\_

***Additional person who may be called in an EMERGENCY***

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Cell:** \_\_\_\_\_

**Names of person(s) authorized to take child from facility:**

\_\_\_\_\_ **Relationship:** \_\_\_\_\_  
\_\_\_\_\_ **Relationship:** \_\_\_\_\_  
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\_\_\_\_\_ **Relationship:** \_\_\_\_\_  
\_\_\_\_\_ **Relationship:** \_\_\_\_\_

***Child's Health Checklist***

1. Is your child taking any medication? If so, what? \_\_\_\_\_
2. Does your child have any allergies? If so, what? \_\_\_\_\_
3. Does your child have any medical problem(s) that would interfere with physical activity? If so, explain:  
\_\_\_\_\_

***Consent for Medical Treatment***

As the parent, agency representative of legal guardian, I hereby give consent for (facility name) \_\_\_\_\_ to provide all emergency dental or medical care prescribed by a duly licensed physician (M.D.) or dentist (D.D.S.) for (child's name) \_\_\_\_\_. This care may be given under whatever condition(s) are necessary to preserve the life, limb, or well-being of my dependent.

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Parent/Guardian Signature:** \_\_\_\_\_