



**YOUTH ACTION COMMUNITY COUNCIL
OF BOONE COUNTY, INC.**

ADDRESSING THE NEEDS OF BOONE COUNTY YOUTH AND THEIR FAMILIES

1122 N. Lebanon St.
Lebanon, IN 46052
(765) 482-0498
(765) 482-0674 fax

Office Use Only
Deposit Payment:
Date:
Payment Method Card <input type="checkbox"/> Check <input type="checkbox"/> Cash <input type="checkbox"/>
Check #:
Amount:
Attendance Payment:
Payment Method Card <input type="checkbox"/> Check <input type="checkbox"/> Cash <input type="checkbox"/>
Check #:
Amount:

BASE

BEFORE & AFTER SCHOOL REGISTRATION AND PROGRAM TUITION FEES
2011/2012
Lebanon and Western Boone School Corporations

REGISTRATION FEES - ALL PLANS Section 1	\$100.00 total Deposit Required - \$35.00 Registration and \$65.00 applied to final week attendance Non Refundable – Non Transferable
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PLAN 1

Full time Rates	Weekly Fee	Full time Rates	Weekly Fee
Before School	4 to 5 days	After School	4 to 5 days
Per Child	\$36.00	Per Child	\$36.00
Additional Children	\$33.00	Additional Children	\$33.00

PLAN 2

PLAN 3

Full time Rates	Weekly Fee
Before and After School	4 to 5 days
Per Child	\$66.00
Additional Children	\$63.00

For your convenience, the annual fee can be divided into equal monthly payments not including fall winter or spring break fees. Advance payments are accepted at any time. Monthly payments after initial registration can be made at the Youth Action Community council office (1122 N. Lebanon st. Lebanon Indiana 46052), by mail, or by phone (Credit card or E-checks). Payment can be set up with automatic reoccurring bank or credit card debits, by completing appropriate authorization forms. Registration hours are Monday-Friday, 9:00 AM-4:00 PM.

(NOTE: Charge and Debit card transactions will be subject to a 3% surcharge)

PLAN 4

Full time Rates	Monthly Fee	Full time Rates	Monthly Fee
Before School	4 to 5 days	After School	4 to 5 days
Per Child	\$133.50	Per Child	\$133.50
Additional Children	\$127.50	Additional Children	\$127.50

PLAN 5

PLAN 6

Full time Monthly Rates	Monthly Fee
Before and After School	4 to 5 days
Per Child	\$244.50
Additional Children	\$233.50

PART TIME PLANS

AS NEEDED CARE

Part time Rates	Single session Fee	Part time Rates	Single session Fee
Before School	Per each session	After School	Per each session
Per Child(Prepaid card)	\$14.00	Per Child(Prepaid card)	\$14.00
Per Child (Emergency)	\$18.00	Per Child (Emergency)	\$18.00

PLAN 7

Part time Rates	Weekly Fee
Before School	Must be enrolled for A minimum of 3 days
1 st Child	\$40.00
Additional Children	\$38.00

PLAN 8

Part time Rates	Weekly Fee
After School	Must be enrolled for A minimum of 3 days
1 st Child	\$40.00
Additional Children	\$38.00

PLAN 9

Part time Rates	Weekly Fee
Before and After School	Must be enrolled for A minimum of 3 days
1 st Child	\$76.00
Additional Children	\$73.00

<u>CHOSEN PLAN:</u>		<u>DAYS ATTENDING</u>				
<u>PLAN#:</u>		<u>MONDAY</u>	<u>TUESDAY</u>	<u>WEDNESDAY</u>	<u>THURSDAY</u>	<u>FRIDAY</u>
<u>INITIALS:</u>						

By signing this document I the undersigned agree to take responsibility for any financial obligation associated with the plan chosen for our child/children's BASE program attendance according to the Parent Handbook guidelines and as listed below.

Enrollment in the Before and After School Program is for the **entire school year not including fall winter or spring breaks**. A \$100 non-refundable down-payment is due at the time of registration. A \$35.00 registration fee will be derived from your deposit with the remainder applied to your child's last week attendance fee.

The first payment of the plan chosen will have to be made in full prior to the child's first day of attendance.

The on-going attendance fee will need to be paid in full as per described below:

For your convenience, the annual fee can be divided into equal monthly payments not including fall winter or spring break fees. Advance payments are accepted at any time. Monthly payments after initial registration can be made at the Youth Action Community council office (1122 N. Lebanon st. Lebanon Indiana 46052), by mail, or by phone (Credit card or E-checks). Payment can be set up with automatic reoccurring bank or credit card debits, by completing appropriate authorization forms. Registration hours are Monday-Friday, 9:00 AM-4:00 PM. (Coming soon ONLINE PAYMENTS)

If you are registered for the Monthly payments, they are due by the 25th of the preceding month. (Example, October payment is due by September 25th). Payments received after the 25th of each month will be charged a \$10 late fee. Students whose balance has not been paid before the first of each month cannot be admitted into the program. If you are set up on a weekly payment program, payments are due by the Friday preceding the week of attendance. Payments received after the deadline will be charged a \$10 late fee. Students whose balance has not been paid before the first of each week cannot be admitted into the program. Thank you for your understanding and cooperation. Participants receiving financial assistance from state/federal programs will be required to pay the entire portion of their fee at time of registration.

Father's signature DATE

Mother's signature DATE

GENERAL REGISTRATION 2011-2012 – Section 2

Today's date:	School:
Attendance Start Date:	Attendance End Date:
Handbook received on date of registration: <input type="checkbox"/> Yes <input type="checkbox"/> No	Method of Handbook Receipt: <input type="checkbox"/> Internet <input type="checkbox"/> Mailed <input type="checkbox"/> Office

Number of children registered:

CHILD INFORMATION

1) Child's Name	Last	First	Middle	Name Used:	DOB: Gender: Age: Grade:
2) Child's Name	Last	First	Middle		DOB: Gender: Age: Grade:
3) Child's Name	Last	First	Middle		DOB: Gender: Age: Grade:
4) Child's Name	Last	First	Middle		DOB: Gender: Age: Grade:

PARENT INFORMATION: NOTE : If you are divorced, please be sure to list the name of the custodial parent at the bottom of the parent information section. Please list where applicable. Please provide BASE a copy of custody agreement. Please list all phone numbers required as it is are only means of contact in case of emergencies.

Child's parent/guardian name	10 Digit Home Telephone Number:	10 Digit Work Telephone Number:
Relationship: Email:	10 Digit Cell phone Number:	10 Digit Alternative Number:
Home Street Address	City	State and Zip Code
Work Street Address	City	State and Zip Code

Where can you best be reached while your child is in BASE Care		Home: <input type="checkbox"/>	Work: <input type="checkbox"/>
Child's parent/guardian name	10 Digit Home Telephone Number:	10 Digit Work Telephone Number:	
Relationship: Email:	10 Digit Cell phone Number:	10 Digit Alternative Number:	
Home Street Address	City	State and Zip Code	
Work Street Address	City	State and Zip Code	

Where can you best be reached while your child is in BASE Care		Home: <input type="checkbox"/>	Work: <input type="checkbox"/>
Name of custodial parent:	Type of custody:	Divorce/custody Decree provided: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Child(ren) Lives with: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both <input type="checkbox"/> Other	Name of Other:	Relationship:	

PARENT EMPLOYMENT INFORMATION

Father's Social Security Number:	Name of Employer:	Nature of Business:
Position:	Years of Employment:	<u>Additional Coments:</u>
Mother's Social Security Number:	Name of Employer:	Nature of Business:
Position:	Years of Employment:	<u>Additional Coments:</u>

OTHER PERSONS TO NOTIFY IN CASE OF EMERGENCY (IF PARENTS CAN NOT BE REACHED)

Any and all changes to the following lists must be done and received by Base in writing – Children will not be released to anyone not named BY YOU as authorized personnel. NO EXCEPTIONS

NAME:	ADDRESS:	10 DIGIT TELEPHONE NUMBER: HOME: WORK: CELL:
RELATIONSHIP:		
NAME:	ADDRESS:	10 DIGIT TELEPHONE NUMBER: HOME: WORK: CELL:
RELATIONSHIP:		
NAME:	ADDRESS:	10 DIGIT TELEPHONE NUMBER: HOME: WORK: CELL:
RELATIONSHIP:		
NAME:	ADDRESS:	10 DIGIT TELEPHONE NUMBER: HOME: WORK: CELL:
RELATIONSHIP:		

OTHER THAN YOU, WHO HAS PERMISSION TO PICK UP YOUR CHILD(REN),?

NAME:	ADDRESS:	10 DIGIT TELEPHONE NUMBER: HOME: WORK: CELL:
RELATIONSHIP:		
NAME:	ADDRESS:	10 DIGIT TELEPHONE NUMBER: HOME: WORK: CELL:
RELATIONSHIP:		
NAME:	ADDRESS:	10 DIGIT TELEPHONE NUMBER: HOME: WORK: CELL:
RELATIONSHIP:		
NAME:	ADDRESS:	10 DIGIT TELEPHONE NUMBER: HOME: WORK: CELL:
RELATIONSHIP:		

WHO DOES NOT HAVE PERMISSION TO PICK UP YOUR CHILD(REN)?

NAME:	REASON:	PROTECTIVE/NO CONTACT ORDER IN PLACE: <input type="checkbox"/> yes <input type="checkbox"/> No (If yes, please provide copy)
NAME:	REASON:	PROTECTIVE/NO CONTACT ORDER IN PLACE: <input type="checkbox"/> yes <input type="checkbox"/> No (If yes, please provide copy)
NAME:	REASON:	PROTECTIVE/NO CONTACT ORDER IN PLACE: <input type="checkbox"/> yes <input type="checkbox"/> No (If yes, please provide copy)
NAME:	REASON:	PROTECTIVE/NO CONTACT ORDER IN PLACE: <input type="checkbox"/> yes <input type="checkbox"/> No (If yes, please provide copy)

CHILD'S HEALTH INFORMATION: Please fill out separate child's health Information sheet for each child enrolled

Date of Child's last physical examination:	Child's Health care provider:	10 digit Telephone Number:
Health Care Provider Street Address:	City:	State and Zip Code:
<p>Special Health Issues: Please Provide Documentation and Explanation: Does your child have or ever had any of the following?</p> <p>ADHD or ADD <input type="checkbox"/>Yes / <input type="checkbox"/> No Heart Disease <input type="checkbox"/>Yes / <input type="checkbox"/> No Asthma <input type="checkbox"/>Yes / <input type="checkbox"/> No Heart Murmur <input type="checkbox"/>Yes / <input type="checkbox"/> No Bleeding Problems <input type="checkbox"/>Yes / <input type="checkbox"/> No Kidney Disease <input type="checkbox"/>Yes / <input type="checkbox"/> No Cancer <input type="checkbox"/>Yes / <input type="checkbox"/> No Liver Disease <input type="checkbox"/>Yes / <input type="checkbox"/> No Depression/Anxiety <input type="checkbox"/>Yes / <input type="checkbox"/> No Neurological Disorder <input type="checkbox"/>Yes / <input type="checkbox"/> No Diabetes <input type="checkbox"/>Yes / <input type="checkbox"/> No Seizure Disorder <input type="checkbox"/>Yes / <input type="checkbox"/> No Gastroesophageal Reflux (GERD)<input type="checkbox"/>Yes / <input type="checkbox"/> No Syndrome <input type="checkbox"/>Yes / <input type="checkbox"/> No Gastrointestinal Disorders <input type="checkbox"/>Yes / <input type="checkbox"/> No Epilepsy <input type="checkbox"/>Yes / <input type="checkbox"/> No Physical Disabilities <input type="checkbox"/>Yes / <input type="checkbox"/> No Learning disabilities <input type="checkbox"/>Yes / <input type="checkbox"/> No Other <input type="checkbox"/>Yes / <input type="checkbox"/> No Please Describe Other and Yes Answers from above:</p>	Allergies, including Drug Reactions	Regular Medications and Dosage: (A form release/authorization must be on file at the BASE site and office for each year and for any medication, prescribed or over the counter non-prescribed, to be administered during the BASE program attendance period. Prescription medication will require a doctor's signature to be administered by any BASE personnel.)
Does your child have any chronic or existing diseases or additional medical problems: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:	
Does your child take medication daily: <input type="checkbox"/> Yes / <input type="checkbox"/> No If Yes, please list name of medication(s): 1) 2) 3) 4)	Dosages and purpose: 1) 2) 3) 4)	Times given: 1) 2) 3) 4)

ADDITIONAL CHILD'S HEALTH INFORMATION: (Please copy this page prior to filling out for every additional child)

CHILD'S HEALTH INFORMATION: Please fill out separate child's health Information sheet for each child enrolled

Date of Child's last physical examination:	Child's Health care provider:	10 digit Telephone Number:
Health Care Provider Street Address:	City:	State and Zip Code:
<p>Special Health Issues: Please Provide Documentation and Explanation: Does your child have or ever had any of the following?</p> <p>ADHD or ADD <input type="checkbox"/> Yes / <input type="checkbox"/> No Heart Disease <input type="checkbox"/> Yes / <input type="checkbox"/> No Asthma <input type="checkbox"/> Yes / <input type="checkbox"/> No Heart Murmur <input type="checkbox"/> Yes / <input type="checkbox"/> No Bleeding Problems <input type="checkbox"/> Yes / <input type="checkbox"/> No Kidney Disease <input type="checkbox"/> Yes / <input type="checkbox"/> No Cancer <input type="checkbox"/> Yes / <input type="checkbox"/> No Liver Disease <input type="checkbox"/> Yes / <input type="checkbox"/> No Depression/Anxiety <input type="checkbox"/> Yes / <input type="checkbox"/> No Neurological Disorder <input type="checkbox"/> Yes / <input type="checkbox"/> No Diabetes <input type="checkbox"/> Yes / <input type="checkbox"/> No Seizure Disorder <input type="checkbox"/> Yes / <input type="checkbox"/> No Gastroesophageal Reflux (GERD) <input type="checkbox"/> Yes / <input type="checkbox"/> No Syndrome <input type="checkbox"/> Yes / <input type="checkbox"/> No Gastrointestinal Disorders <input type="checkbox"/> Yes / <input type="checkbox"/> No Epilepsy <input type="checkbox"/> Yes / <input type="checkbox"/> No Physical Disabilities <input type="checkbox"/> Yes / <input type="checkbox"/> No Learning disabilities <input type="checkbox"/> Yes / <input type="checkbox"/> No Other <input type="checkbox"/> Yes / <input type="checkbox"/> No Please Describe Other and Yes Answers from above:</p>	Allergies, including Drug Reactions	Regular Medications and Dosage: (A form release/authorization must be on file at the BASE site and office for each year and for any medication, prescribed or over the counter non-prescribed, to be administered during the BASE program attendance period. Prescription medication will require a doctor's signature to be administered by any BASE personel.)
Does your child have any chronic or existing diseases or additional medical problems: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:	
Does your child take medication daily: <input type="checkbox"/> Yes / <input type="checkbox"/> No If Yes, please list name of medication(s): 1) 2) 3) 4)	Dosages and purpose: 1) 2) 3) 4)	Times given: 1) 2) 3) 4)

AUTHORIZATION TO OBTAIN MEDICAL TREATMENT FOR MINOR CHILD

WITNESS THIS AGREEMENT AND AUTHORIZATION by and between Youth Action Community Council of Boone County, INC., hereinafter referred to as "Management" and: _____, hereinafter referred to as "Parent."

Management is hereby authorized to obtain any and all medical treatment Management deems reasonably necessary for my minor child and/or children during their attendance in BASE programs.

Parent or guardian agrees to bear any cost connected therewith and shall pay promptly upon billing by the health care provider. Management shall incur no financial liability for medical treatment obtained pursuant to this authorization.

Name(s) of Child (ren) and Social Security Number

Health Insurance Carrier: _____

Plan or Identification Number: _____

Primary Health Care Provider & Telephone Number: _____

Parent's Names and Emergency Telephone Numbers: _____

Mother's Name Work Telephone Home Telephone Cell Phone _____

Father's Name Work Telephone Home Telephone Cell Phone _____

WAIVER OF LIABILITY

I, _____ (Parent/Legal Guardian), hereby release **Youth Action Community Council and/or Mental Health Association in Boone County** (companies) from any and all liability connected with my son(s)/daughter(s) participation in the companies' programs and recreational activities. I acknowledge that they are participating in these activities on their own time and of their own choice and assume all risk in connection thereto.

Initials _____

Consent to transport and waiver of liability

I hereby give consent for **Youth Action Community Council and/or Mental Health Association in Boone County** (companies) staff members and Case Managers the right to transport my child/children _____ to the proper medical facility if such became necessary and/or to and from field trips. I waive my rights to hold **Youth Action Community Council and/or Mental Health Association in Boone County** (companies) officers, agents, employees and/or any affiliated companies responsible for any liabilities arising from injuries my child/children and/or myself might suffer while transporting and/or participating in services. I understand and agree that **Youth Action Community Council and/or Mental Health Association in Boone County** (companies) staff shall provide only that emergency treatment that is within its capabilities and that I assume full responsibility for any and all medical expenses incurred as a result of any injuries suffered. **Initials** _____

Signature of Parent or Guardian

Signature of Parent or Guardian

NOTE: THIS FORM MUST BE NOTIRIZED
STATE OF (_____)

)SS:

COUNTY OF (_____)

The foregoing instrument was subscribed and sworn to before me by _____, Parent or Guardian, on the ____ day of _____, _____.

NOTARY PUBLIC
My commission expires: _____

PARENT AGREEMENT:

Please read the following and sign below

1. For the School year enrolled, I agree to pay as per described in the plan I chose in section one.
2. I understand that if any signature page or initial section is left unsigned, my child will not be allowed into the program until they are signed.
3. I have read, understand and agree with all guidelines and policies as set forth and included in the Parent Handbook.
4. I have read, understand and agree with all payment procedures as described in section 1 of this registration and the Parent Handbook.
5. Parents will be responsible for all expenses incurred for medical and/or transportation cost of the child.
6. Parents agree to have an adult sign in the child for AM BASE and an adult sign out the child from PM BASE.
7. I agree to sign an authorization of release of information regarding my child's needs with the school he or she attends, Mental Health America of Boone County and BASE.
8. I understand that all BASE personnel are mandated to report any signs or conversation of abuse and neglect to the appropriate authorities.

PARENT/GUARDIAN SIGNATURE

DATE

PRINTED NAME

DATE

PARENT/GUARDIAN SIGNATURE

DATE

PRINTED NAME

DATE

BASE is administered by Youth Action Community Council
1122 N. Lebanon St.
Indiana, 46052
www.bccn.boone.in.us/yacc

Parent Release Form for Media Recording

I, the undersigned, do hereby grant or deny permission to Youth Action Community Council to use the image of my child, _____, as marked by my selection(s) below. Such use includes the display, distribution, publication, transmission, or otherwise use of photographs, images, and/or video taken of my child for use in materials that include, but may not be limited to, printed materials such as brochures and newsletters, videos, and digital images such as those on the Youth Action Community Council Web site.

- Deny permission to use my child's image at all.
- Grant permission to use my child's image in the following ways (mark all that apply):
 - Limited usage:** I want my child's image used within the Youth Action Community Council setting only (not in the larger community).
 - Limited usage:** I want my child's image used for educational materials only (not marketing). This could be either within Youth Action Community Council or in the larger community. One example of this could be videos in parent education classes.
 - Limited usage:** I want my child's image used on printed materials only (no digital or video use).
 - Unrestricted usage:** I give unrestricted permission for my child's image to be used in print, video, and digital media. I agree that these images may be used by Youth Action Community Council for a variety of purposes and that these images may be used without further notifying me. I do understand that the child's last name will not be used in conjunction with any video or digital images.

Parent/guardian signature _____ Date _____

Please make a copy of this form for your own records and return the original to:

Youth Action Community Council

1122 N. Lebanon Street
Lebanon Indiana, 46052

765 482 0498
FAX: 765 482 0674
yacc@ilines.net