

FLYING COLORS

AFTER SCHOOL PROGRAM

School Year 2011-12

September 6, 2011-June 18, 2012

2:30*-5:30 pm

APPLICATION DEADLINE: August 31, 2011

Child Application

Serving children ages 5-12 years old

FOR OFFICE USE ONLY

STUDENT NAME: _____
P2 Filled _____ P2 Approved _____
MedRel _____ LiabRel: _____ Immnz: _____
Doctor: _____
PAYMENT: F _____ SSR _____ SSF _____
TRANS _____ ROUTE: _____
TEACHERS: _____
GROUP #: _____

Rebound of Whatcom County
1405 N Forest St.
Bellingham, WA 98225
360-714-0700
www.reboundwc.org



Rebound of Whatcom County



Bringing Hope and Healing to Families in Whatcom County

Rebound of Whatcom County is committed to equipping, strengthening and empowering children and families facing difficult life circumstances by working cooperatively with public and private organizations to build community through practical expressions of faith.

Flying Colors After-Care Program

Program Description

Flying Colors is an after-care program following the school day that focuses on maintaining and strengthening academic skills in reading, writing, and math throughout the year. Certified teachers facilitate the program to maximize learning.

- Dates and Times: September 6, 2011– June 19 2012, Monday-Friday from 2:30pm-5:30pm.
- Flying Colors operating hours follow the school district dismissal times. The actual time your child will begin Flying Colors each day may be different from other children, depending on school and district. Please see director for further questions.
- Location: Northwest Baptist Church
- \$70 per week.
- DSHS & DCFS childcare benefits may apply. Contact your social worker to see if you qualify

Flying Colors Goals

- To provide students with unique, age-appropriate, and hands-on activities that will encourage creativity and positive thinking.
- To encourage students through relationships with supportive, caring adults and mentors.
- To empower students to believe they can be successful in school.

Please fill out all forms for each child. Your application will be returned to you if it is not completely filled out. All information is confidential.

Child's Name: _____

Address: _____ City/State/Zip: _____

Child is Living with (circle one): Parent Foster Parent Group Home Relative

Parent/Guardian Name (please print): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Grade (Fall 2011): _____ Birthdate: _____ Age as of Sept. 1st: _____ Male _____ Female _____

School Attending: _____ Teacher's name (Fall 2011): _____

Emergency Contact Person Other Than Self (Required): _____ Phone: _____

Relationship to Child: _____

I am receiving: TANF Basic Food TANF# _____ Basic Food # _____

Case #'s: _____

Name of Caseworker: _____ Phone: _____

Agency: _____ Email Address: _____

Name of Person Filling out this Application: _____

Phone: _____ E-mail: _____

Flying Colors is a Washington state licensed childcare center and therefore may be eligible for DSHS childcare benefits—contact your caseworker for more details. Part II Childcare Assistance form will need to be filled out.

CAREGIVER CONTRACT

- Part of Flying Colors staff training includes Right Response containment training. By signing below you give staff permission to utilize the training that is provided to them to keep your child, other children, and the staff safe. For more information on the techniques used for physically keeping children safe, please contact Sharon Aller at 714-0700.
- I will call in advance & leave a message if my child is unable to attend. If I am receiving DSHS or DCFS childcare benefits, I understand my child's position may be taken by another camper on the waiting list if I have more than **3** unexcused absences. _____ (initial here)
- For self-pay, all parent co-pays will be collected prior to the first calendar day each month. If you would like to set up a payment plan please fill out the details on the parent payment plan section.
- Pictures and video may be taken of my child and possibly used for Flying Colors promotional materials _____ (initial here)

I have read and agree to the above:

Caregiver Signature: _____ Date: _____

ACADEMIC INFORMATION
2011-12 School Year

STUDENT'S NAME: _____

Name of Child's School: _____

District: _____

Teacher's Name: _____ Grade entering: _____

Teacher or School Phone #: _____

	Excels	Meets standards	Struggles	Receives special education services	Don't Know/N/A
Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Math	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Science	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Details from above: _____

Does your child have a current:

- IEP Yes No Unsure
- 504 Plan Yes No Unsure
- Behavior Plan Yes No Unsure

IF YES TO ANY OF THE ABOVE, PLEASE PROVIDE US WITH A COPY.

Diagnosed Learning Disability: _____ N/A

What are your educational goals for your student?

STUDENT'S EMOTIONAL/BEHAVIOR HISTORY:

Please answer these questions honestly as it helps us to evaluate how best to serve your child.

STUDENT'S NAME: _____

	Often	Sometimes	Not at all		Often	Sometimes	Not at all
Aggressiveness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Biting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eating Disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Hyperactivity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Learning Disabilities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Lying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Runs Away	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Sexual Acting Out	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Steals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Tantrums	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Withdrawn	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Low Self-Esteem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Details from above:

Please describe recent family circumstances or experiences that may affect your child's behavior at Flying Colors (*divorce, recent move, loss of a parent, domestic violence, sexual assault, death of a family member, exclusion from school, etc.*):

List any special interests, activities or hobbies that your child enjoys or makes him/her feel special:

Has your child attended Flying Colors in previous years? No _____ Yes _____ When: _____

FLYING COLORS MEDICAL FORM

Student's Name: _____ Medical Insurance Company: _____

Group Number: _____ Policy Number: _____

Student's Doctor Name: _____ Doctor's Phone Number: _____

Date of Last Physical Exam: _____ Date of Last Dental Exam: _____

****Please attach a copy of child's immunization record with application.****

Medical Release:

My child has permission to engage in all prescribed program activities, except as noted below. The undersigned do hereby authorize the directors of Flying Colors or such substitute as they may designate as agent for the undersigned to consent to an X-Ray examination, anesthetic, medical, dental or surgical diagnosis or treatment and hospital care for the minor which is deemed advisable by and to be rendered under the general or special supervision of any physician and surgeon, licensed under the provision of the Medical Practice Act or any dentist licensed under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, or hospital, camp or elsewhere. This authorization remains effective while the above said minor is en route to and from or involved or participating in any camp program, unless revoked in writing by the undersigned and delivered to the Flying Colors camp director.

Permission to Administer Over the Counter Medication:

I hereby give Flying Colors staff permission to administer the following products according to manufacturer's instructions. I trust Flying Colors staff to use their best judgment as situations arise, and, if in doubt, he/she can call for verification.

Please circle YES or NO for medication listed below:

OTC Medication:

Other Instructions:

Sunblock	YES/NO	_____
Insect Repellant	YES/NO	_____
Lip Balm	YES/NO	_____
Tylenol	YES/NO	_____
Antiseptic Ointment	YES/NO	_____
Band-Aids	YES/NO	_____
Anti-Itch Cream	YES/NO	_____
Hydrogen Peroxide	YES/NO	_____
Cough Syrup	YES/NO	_____
Cough Drops	YES/NO	_____
Decongestant	YES/NO	_____
Antihistamine	YES/NO	_____
Ipecac Syrup	YES/NO	_____

Please indicate any medication child is taking (please print clearly):

All medication sent to FC must be in original container with the pharmacy label on it and given to a staff person at sign-in

Medication	Diagnosis for Medication	Dosage	Time	Taken at Flying Colors?
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____

Please indicate any known allergies (medicine, food, hay fever, insect bites, etc.)

1. _____
2. _____

Please indicate any current illnesses, disabilities or injuries (physical or mental):

1. _____
2. _____

Parent/Caregiver Signature:

I certify that the above medical information is true, accurate, and up to date to the best of my knowledge.

Parent or Guardian Signature: _____

Date: _____

SIGN-IN/SIGN-OUT INFORMATION

STUDENT'S NAME: _____

How will your student arrive to Flying Colors Program (circle one): **Flying Colors Staff** **I will Provide**

The following persons are authorized to pick up my child from Flying Colors:

Name _____	Relationship _____	Phone _____	Cell _____
Name _____	Relationship _____	Phone _____	Cell _____
Name _____	Relationship _____	Phone _____	Cell _____

Please let authorized persons know they will need to present a picture ID at pick-up.

The following persons are **NOT** authorized to pick up my child from Flying Colors:

Name _____	Relationship _____
Name _____	Relationship _____

PAYMENT PLAN

Flying Colors is a licensed childcare program and we accept DSHS and DCFS childcare payment for tuition.

Payment Options:

- Department of Child and Family Services (DCFS) Childcare Assistance will cover camp fees.
- Department of Social and Health Services (DSHS) Childcare Assistance will cover camp fees. *(Please fill out Part II Child Care Assistance Form — see social worker for details).*
- I am covering the fee in full payable in weekly / monthly payments (circle one)
- There are limited partial scholarships available. Scholarship application is required. Call 714-0700 or visit www.reboundwc.org for an application today!

Parent/Guardian Signature: _____ Date: _____

REBOUND OF WHATCOM COUNTY & FLYING COLORS
RELEASE OF LIABILITY

The undersigned is the parent of legal guardian of the below named Minor. The undersigned desires for said Minor to attend and/or participate in ministries, events, programs, functions and activities (hereinafter referred to as "Activities"), sponsored by, connected with or related to Rebound of Whatcom County, Inc., a Washington State not-for-profit corporation (Rebound) or the Youth Camp, a not-for-profit corporation (Camp).

I understand and acknowledge that Flying Colors will not allow the Minor to participate in any Rebound Activity without release and holding Rebound harmless from any liability arising out of the Minors' attendance and/or participation in that Activity, including the Minors' transportation to and from the Activity, if provided by Flying Colors and/or Rebound.

I have and will investigate all risks involved with the Minors' attendance and/or participation in and Activity, and further, as the parent or legal guardian of said Minor, assume and all risks of personal or bodily injury to said Minor or property damages associated with said Activity.

By signing this document, on behalf of myself and the Minor, I hereby release and forever discharge Rebound, its officers, directors, and employees, agents, and any parties volunteering on behalf of Rebound from all claims, damages, costs or expenses of any kind arising out of or related to the Minor's attendance or participation in Rebound or Flying Colors activities. I understand that this document is a full complete release of all claims or personal or bodily injury and property damage that the Minor might sustain as the results of the Minor's attendance and/or participation in any Rebound Activity, regardless of the specific cause thereof, and I further understand that in the event of such personal or bodily injury to the minor, or property damage, that I cannot seek on behalf of the Minor or myself any type of recovery or reimbursement whatsoever from Rebound or their officers, directors, employees, agents, or any parties volunteering on behalf of Rebound or Flying Colors.

Name of Child/Children (printed): _____

Caregiver Name (printed): _____

Caregiver Signature: _____

REBOUND OF WHATCOM COUNTY AND FLYING COLORS
ACADEMIC INFORMATION CONSENT

Flying Colors Tutoring Program may need to contact the student's school personnel in order to better serve the student's particular needs. School districts require parent/guardian consent in order to share relevant academic information regarding a student. Relevant academic information may include, but is not limited to, grades, group tests scores, IEP (Individualizes Education Plan) and vision information. It is anticipated that the school district may share such information with Flying Colors Staff in writing, over the phone, or in face-to face conversations. Within Flying Color's and Rebound Programs, relevant academic information regarding a student will be shared only among Flying Color's leadership team and the particular student's tutor.

I give permission to _____ (student's school)
to share relevant academic information regarding _____ (name of student)
with Flying Colors and Rebound staff. I understand that this consent is effective
throughout the 2011-12 school year.

Parent/Guardian's Signature: _____

Parent/Guardian Name (Printed): _____ Date: _____

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