



# After School Enrollment Form 2017-2018

Kids Inc. 201 E. 38th St. Sioux Falls, SD 57105  
Phone 605.367.4424 Fax 605.367.4493

**PARENT/GUARDIAN PLEASE FILL OUT:**

SCHOOL: \_\_\_\_\_

START DATE: **9/5/17 – 1st day of school**

**CHILD(REN)'S INFORMATION: Please PRINT**

**CHILD 1:**

Name (Last, First)	Grade (2017/18 school year)	Male or Female (Circle One)	Date of Birth
Has a medical provider prescribed medication(s) or treatment(s) that must be given to your child during Kids Inc.? YES NO If YES, please identify the medical condition(s) and list the medication(s) or treatment(s):			
Has your child's medical provider placed any restrictions or limitations on your child due to a medical condition? YES NO If YES, please list the medical condition(s) and list those restrictions or limitations:			
Does your child require the use of any rescue medication(s) (i.e. Epi Pen, seizure medication, inhaler, glucagon)? YES NO If YES, please list the medical condition(s) and the medication(s):			
Does your child have a Special Diet on file with the SFSD's Child Nutrition program? YES NO If YES, please explain:			
Is there any other information that would be helpful for us to know regarding your child's behavior or personality?			

**CHILD 2: (if applicable)**

Name (Last, First)	Grade (2017/18 school year)	Male or Female (Circle One)	Date of Birth
Has a medical provider prescribed medication(s) or treatment(s) that must be given to your child during Kids Inc.? YES NO If YES, please identify the medical condition(s) and list the medication(s) or treatment(s):			
Has your child's medical provider placed any restrictions or limitations on your child due to a medical condition? YES NO If YES, please list the medical condition(s) and list those restrictions or limitations:			
Does your child require the use of any rescue medication(s) (i.e. Epi Pen, seizure medication, inhaler, glucagon)? YES NO If YES, please list the medical condition(s) and the medication(s):			
Does your child have a Special Diet on file with the SFSD's Child Nutrition program? YES NO If YES, please explain:			
Is there any other information that would be helpful for us to know regarding your child's behavior or personality?			

**CHILD 3: (if applicable)**

Name (Last, First)	Grade (2017/18 school year)	Male or Female (Circle One)	Date of Birth
Has a medical provider prescribed medication(s) or treatment(s) that must be given to your child during Kids Inc.? YES NO If YES, please identify the medical condition(s) and list the medication(s) or treatment(s):			
Has your child's medical provider placed any restrictions or limitations on your child due to a medical condition? YES NO If YES, please list the medical condition(s) and list those restrictions or limitations:			
Does your child require the use of any rescue medication(s) (i.e. Epi Pen, seizure medication, inhaler, glucagon)? YES NO If YES, please list the medical condition(s) and the medication(s):			
Does your child have a Special Diet on file with the SFSD's Child Nutrition program? YES NO If YES, please explain:			
Is there any other information that would be helpful for us to know regarding your child's behavior or personality?			

**PARENT / GUARDIAN INFORMATION: Please PRINT**

Anyone listed in the 'Parent/Guardian Information' section below has the ability to: *authorize pick-up changes, change enrollment status and change financial arrangements on the account unless court documentation is provided stating otherwise. Mailings and tax statements will be mailed to the address listed in the 'Parent/Guardian A' area below.*

**PARENT/GUARDIAN A: (Required)- Person requesting enrollment**

Name	Relation to Child	Employer	
Address	City & State	Zip	Cell #
Cell Provider (Verizon, AT&T, Sprint, etc...to receive minimal texts)	Email (to receive reminders, updates, notices, etc...)	Home #	Work #

**PARENT/GUARDIAN B: (If applicable)**  Check here if 'Parent/Guardian B' address is the same as 'Parent/Guardian A'

Name	Relation to Child	Employer	
Address	City & State	Zip	Cell #
Cell Provider (Verizon, AT&T, Sprint, etc...to receive minimal texts)	Email (to receive reminders, updates, notices, etc...)	Home #	Work #

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**EMERGENCY CONTACT INFORMATION: Please PRINT**

For child's safety, list all persons, OTHER THAN 'PARENT/GUARDIAN A OR B', who are authorized to pick up child(ren) and/or be contacted in case of emergency.  
 \*Minimum of 2 required. Age of pick up person is at the parent/guardian's discretion.

*Name (Required)	*Phone (Required)	Relation to Child
*Name (Required)	*Phone (Required)	Relation to Child
Name	Phone	Relation to Child
Name	Phone	Relation to Child

**PAYMENT INFORMATION:**

FEES:		Please fill out A, B & C:
<b>A. One-time Enrollment Fee:</b> This fee is for each child NEW to the after school program. This fee is nonrefundable.	<b>\$20 per NEW child</b>	_____ x \$20= A.\$_____ (# of NEW children X \$20 Enroll. Fee = A.)
<b>B. Bi-Weekly Fee (Rate for 2 weeks of care):</b> <i>What lunch rate does your child qualify for?</i> → To receive the REDUCED or FREE lunch rate you must fill out the application through Child Nutrition each school year. Please pay the REGULAR rate if you have not applied or are unsure of your lunch rate and we will refund/credit your account for the difference based on the date you qualified, if applicable. Inform the Kids Inc. Office if your rate status changes. **The HEADSTART rate only applies to incoming Kindergarten students who were enrolled in the HEADSTART program last year.	<b>\$80.00 REGULAR</b>	_____ x _____ = B.\$_____ (# of children X Lunch Rate = B.)
	<b>\$65.00 REDUCED</b>	
	<b>\$49.00 FREE</b>	
	<b>*\$29.00 HEADSTART</b>	
<b>NOTE: Refund Policy</b> —If you choose to cancel your Kids Inc. enrollment, a parent/guardian must notify the Kids Inc. Office. If you notify the office of withdrawal <b>BEFORE</b> August 1st you will receive a full refund (minus the nonrefundable enrollment fee). If you notify of withdrawal <b>AFTER</b> August 1st, no refund will be given. <i>Kids Inc. Office Phone Number: 605.367.4424</i>		<b>C. _____</b>
		<b>TOTAL: A. + B. = C.</b>

Check ONE option below: **METHOD OF PAYMENT: Initial payment ('Box C' TOTAL) is due with completed enrollment form.**

- 1. Check/ Cash/ Money Order enclosed- payable to Kids Inc.**
- 2. Run my auto withdrawal account information on file on the upcoming Friday\***  
 \*This method is only for **current Kids Inc. families that are set up on auto pay already.** We need at least 1-2 days to process forms. If you don't see your payment come out on the upcoming Friday, it should come out on the following Friday.
- 3. Bill this card # below (Visa/Mastercard/Discover ONLY)\***  
 Card #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
 Name on card: \_\_\_\_\_ Verification Code(3 digits on back): \_\_\_\_\_  
 \*Card will NOT be kept on file and will be run ASAP. Automatic withdrawal can be set up through your checking or savings account. Submit auto withdrawal card to set up this service.

**TWO-HOUSEHOLD FAMILIES ONLY:** Check here if you will be splitting payments and will need separate billing accounts and tax statements.   
 What percentage will each parent/guardian pay? \_\_\_\_\_

**ACKNOWLEDGEMENT: Please INITIAL on each line. Checkmarks are NOT acceptable. \*Indicates Required**

<b>INITIAL ON LINE:</b>	_____ *I understand that I will be expected to read and abide by the guidelines outlined in the Parent Handbook which will be distributed the first week of school or upon enrollment during the school year.
	_____ *I understand that Kids Inc. staffing ratio of supervision is 1 adult to every 15 children. Please see guidelines in Parent Handbook.
	_____ *If I, or my Emergency Contacts, cannot be reached; I authorize Kids Inc. staff to obtain medical attention for my child if necessary.
	_____ I give permission for Kids Inc. to use the image of my child on video, in print, on the internet or on radio/television broadcasts to help in the positive promotion of the Kids Inc. Program.
	_____ I give permission for the sharing of applicable educational, medical and behavioral information between the Sioux Falls School District staff and Kids Inc. staff.
	_____ <b>*SIGNATURE OF PARENT/GUARDIAN</b> _____ <b>*DATE</b>

**NOTE:** Registration deadlines are set in order to give us enough time to process your enrollment form and make the necessary preparations for your child(ren) before they start Kids Inc. Start dates are every two weeks based on our payment calendar. Forms and payments must be submitted by the Wednesday before a start date. All spots fill on a first come, first serve basis and are dependent on whether there are openings at the school your child attends. Please contact the Kids Inc. office at 605.367.4424 to determine space availability and a start date for your child(ren). If you miss the deadline you will need to wait for the next start date.

**PLEASE RETURN THIS COMPLETED ENROLLMENT FORM ALONG WITH CORRECT PAYMENT TOTAL FROM 'BOX C' ABOVE:**

- MAIL OR DELIVER IN PERSON:** Instructional Planning Center (IPC) - Kids Inc. - 201 E 38th St - Sioux Falls, SD 57105  
**Office hours:** School year: M-F 8:00am - 5pm  
Summer: M-Th 7:30am - 5:30 pm -closed on major holidays -
  - FAX:** 605.367.4493
  - EMAIL:** abby.wheeler@k12.sd.us
- \*We will send an email confirmation once we process the enrollment, if an email address has been provided.\*
- Office Use Only:    \_\_ CL    \_\_ PC    \_\_ AP    \_\_ WL/PH    \_\_ B    \_\_ Conf.