2023-2024 CAA AFTER SCHOOL PROGRAM FAMILY CONTRACT

This contract is made effective as of \_\_\_\_\_\_\_\_\_\_\_\_ by and between the following parties:

“Provider” Croton Academy of Arts (CAA)

 8 Old Post Road South, Croton on Hudson, New York 10520

 afterschool@crotonacademy.org , (914) 862-0988 \ **and**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to child:: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_Croton on Hudson\_\_ NY Zip \_\_\_\_\_\_\_

Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_work number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

 E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To provide care for: Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (a separate contract and health form must be submitted for each child)

The Undersigned Caregiver(s) hereby gives CAA permission to care for the above child(ren) in accordance with this Contract. In consideration of the mutual agreements and covenants contained in the Contract, the parties agree to the following:

**1. CONTRACTED DAYS** The Provider shall provide child care services and the Parent/Guardian shall pay for such services as follows:

❑ Monday ❑ Tuesday ❑ Wednesday ❑ Thursday ❑ Friday

This schedule will be in effect unless terminated sooner by either party in accordance with this Contract.

The Parent/Guardian shall pay child fees for the CAA After School program based on the above schedule at the rates specified below. Fees will not be adjusted for late arrival, early pickup, or missed days, except as provided by the Contract. Partial refunds are given on a case by case basis..

**2. PROGRAM SCHEDULE**

| **CET** 2:30-6:00 pm (grades K-3) 6:30 for late pick up | **PVC** 3:00-6:00 pm (grades 4-7) |
| --- | --- |

**By signing this Contract, the undersigned represents that they understood and agreed to the terms and conditions of this Contract. Breach of this Contract in any way by the Parent/Guardian may result in immediate termination of services.**

Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby release the Directors and all employees of Croton Academy of Arts from all claims of liability for any damage or injuries which may be sustained by my child in the After School program or any class at the CHUFSD.

parent/guardian signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby give permission for my child’s photograph to be used for program purposes.

parent/guardian signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pick up Authorization/ Emergency contact form**

**CHILD’S NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_**

**AUTHORITY TO PICK UP CHILD** The following person(s) has authority to pick up the child(ren)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell number: \_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Parent/Guardian shall inform Croton Academy in advance if someone other than the Parent/Guardian or person(s) listed above will pick up the children.

**DOES NOT HAVE AUTHORITY TO PICK UP CHILD**

The following person(s) does not have authority to pick up the child(ren).

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACTS** In case of emergency, Croton Academy of Arts will first try to reach the Parent/Guardian. CAA will need at least one of the three emergency contacts listed to be local to Croton on Hudson.

1.Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_

Cell Number: \_\_\_\_\_\_Ok to text \_\_\_\_\_ Other phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Cell Number: \_\_\_\_\_\_\_\_\_\_\_Ok to text \_\_\_\_\_\_\_ Other phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: NY\_\_\_\_ Zip: \_\_\_\_\_\_

Cell Number: \_\_\_\_\_\_\_\_\_\_\_\_\_Ok to text \_\_\_\_\_\_ Other phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Croton Academy of Arts is a 501(c) (3) not for profit corporatio****

**OCFS-LDSS -7006** (07/2022) FRONT

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES

**INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS**

You may use this form or an approved equivalent to document an individual health care plan developed for a child with special health care needs.

***A child with a special health care need means a child who has a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and who requires health and related services of a type or amount beyond that required by children generally***.

Working in collaboration with the child’s parent and child’s health care provider, the program has developed the following health care plan to meet the individual needs of:

| CHILD NAME:      | CHILD DATE OF BIRTH:      /       /       |
| --- | --- |
| NAME OF THE CHILD’S HEALTH CARE PROVIDER:      | ☐ Physician☐ Physician Assistant☐ Nurse Practitioner |

Describe the special health care needs of this child and the plan of care as identified by the parent and the child’s health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment.

|  |
| --- |

**Identify the caregiver(s) who will provide care to this child with special health care needs:**

| **Caregiver’s Name** | **Credentials or Professional License Information (if applicable)** |
| --- | --- |
|       |       |
|       |       |

**OCFS-LDSS-7006** (07/2022) REVERSE

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES

**INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS**

Describe any additional training, procedures or competencies the caregiver identified will need to carry out the health care plan for the child with special health care needs as identified by the child’s parent and/or the child’s health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment. In addition, describe how this additional training and competency will be achieved including who will provide this training.

|       |
| --- |

This plan was developed in close collaboration with the child’s parent and the child’s health care provider. The caregivers identified to provide all treatments and administer medication to the child listed in the specialized individual health care plan are familiar with the child care regulations and have received any additional training needed and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

| PROGRAM NAME:      | FACILITY ID NUMBER:      | PROGRAM TELEPHONE NUMBER:(     )       |
| --- | --- | --- |
| CHILD CARE PROVIDER’S NAME (PLEASE PRINT):      | DATE:      /       /       |
| CHILD CARE PROVIDER’S SIGNATURE:**X** |

I agree this Individual Health Care Plan meets the needs of my child. Yes ☐ No ☐

I give consent to share information about my child's allergy with all program caregivers in a non-discreet way. I support the strategies the program implements to keep my child from being exposed to known allergen(s). I acknowledge these strategies may include visual reminders that may result in the disclosure of my child's confidential allergy information to non-child care staff. Yes ☐ No ☐

**Signature of Parent:**

| **X** | DATE:      /       /       |
| --- | --- |

**OCFS-LDSS-0792A** (09/2022) FRONT

|  | NEW YORK STATEOFFICE OF CHILDREN AND FAMILY SERVICES**INDIVIDUAL ALLERGY AND ANAPHYLAXIS EMERGENCY ACTION CARD** |
| --- | --- |
| CHILD’S FULL NAME:       | DATE OF BIRTH:      /       /       | GENDER:       |
| KNOWN ALLERGENS:      | ASTHMA? ☐ YES ☐ NO |
| HISTORY OF ANAPHYLAXIS? ☐ YES ☐ NO |
| POTENTIAL SYMPTOMS:      | MEDICATION/DOSAGE/LOCATION: |
| EXPOSURE ACTION PLAN | 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |



**OCFS-LDSS-0792A** (09/2022) REVERSE

| RISK MANAGEMENT STRATEGIES:     |
| --- |
| NOTES:       |
| EMERGENCY CONTACT(S):       |
| PROVIDER SIGNATURE: X | DATE:      /       /       |
| SIGNATURE – PARENT OR PERSON LEGALLY RESPONSIBLE:X | DATE:      /       /       |