

2010-2011 Before & After School Program

At Elizabeth Shelton School

Serving Elizabeth Shelton & Booth Hill schools

Morning Session

- 7:00-8:45 am
- Shelton school bus will transport Booth Hill students to Booth Hill
- \$125 per month (\$100 per month for siblings)

Afternoon Session

- 3:30-5:30 pm
- Shelton school bus will transport Booth Hill students to Elizabeth Shelton
- \$140 per month (\$110 per month for siblings)

Open on Scheduled Half Days

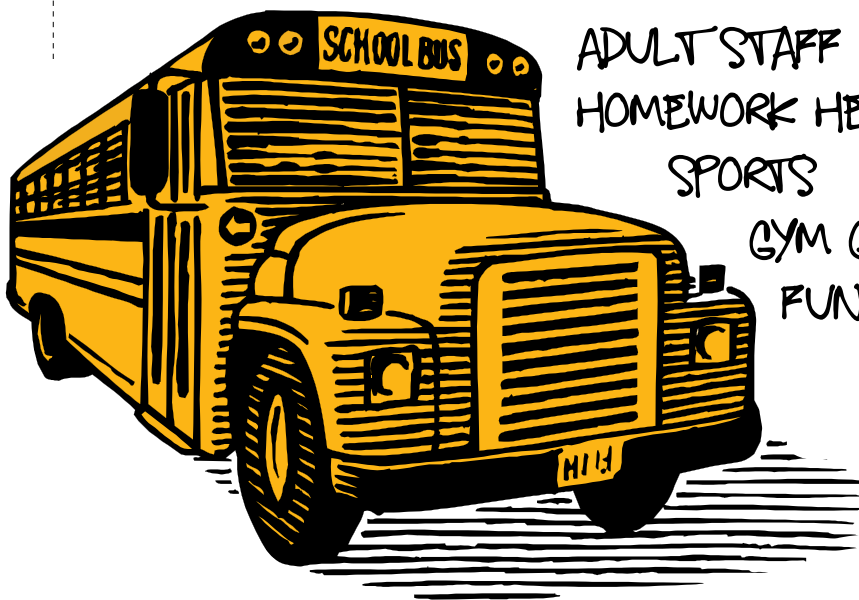
Operated by Boys & Girls Club of the Lower Naugatuck Valley

Register at our Shelton Clubhouse

One Positive Place, Shelton

203-924-7462

Download Membership Application from www.BGC-LNV.com



ADULT STAFF
HOMEWORK HELP
SPORTS
GYM GAMES
FUN ACTIVITIES



BOYS & GIRLS CLUB
OF THE LOWER NAUGATUCK VALLEY



2010-2011 MEMBERSHIP APPLICATION



Where does your child attend school? Elizabeth Shelton Booth Hill

Member's Information

First Name _____ Middle _____ Last _____
Address _____
City _____ State _____ ZIP _____
Phones _____
Date of Birth _____ Age _____ Gender Female Male
Family e-mail _____

Member's School Information

Current Teacher _____
School _____ Grade _____
Lunch Information Free Reduced Do Not Qualify

Member's Contact Information

Father's Name _____ Mother's Name _____
Father's Employer _____ Mother's Employer _____
Father's Work Number _____ Mother's Work Number _____
Father's Cell Number _____ Mother's Cell Number _____

Member's Emergency Contact: EMERGENCY CONTACT CANNOT BE PARENT OR GUARDIAN

Name _____ Relationship to Member _____
Phone Home _____ Work _____ Cell _____

Member's Medical Information

Doctor's Name _____ Doctor's Phone _____
Serious Health Problems? No Yes If when, please explain _____

Member's General Information

Member has permission to be used in public relations materials (newspaper photos, etc.) Yes No
Member lives with: Mom Step Mom Dad Step Dad Grandparent Other _____
Number of Brothers _____ Ages _____ Number of Sisters _____ Ages _____
Number in Household _____ Single Parent Yes No



NOTE: This information is collected for Grant Writing Purposes ONLY

Member's Ethnicity

Gender: Male Female Ethnicity _____

Member's Household Information

Annual Income Level	\$0 - \$5,000 _____	\$30,001 - \$35,000 _____	\$60,001 - \$65,000 _____
	\$5,001 - \$10,000 _____	\$35,001 - \$40,000 _____	\$65,001 - \$70,000 _____
	\$10,001 - \$15,000 _____	\$40,001 - \$45,000 _____	\$70,001 - \$75,000 _____
	\$15,001 - \$20,000 _____	\$45,001 - \$50,000 _____	\$75,001 - \$80,000 _____
	\$20,001 - \$25,000 _____	\$50,001 - \$55,000 _____	\$80,001 - \$85,000 _____
	\$25,001 - \$30,000 _____	\$55,001 - \$60,000 _____	\$85,001 - \$90,000+ _____

Member's Physical Appearance

Eye Color _____ Hair Color _____ Skin Color/Features _____
Height _____ Weight _____

Activities Interested In (Check Parent Handbook for times and availability of activities)

- | | | |
|--|--|--|
| <input type="checkbox"/> Arts & Crafts | <input type="checkbox"/> Basketball | <input type="checkbox"/> Chess |
| <input type="checkbox"/> Computers | <input type="checkbox"/> Cooking | <input type="checkbox"/> Flag Football |
| <input type="checkbox"/> Gamesroom | <input type="checkbox"/> Homework Club | <input type="checkbox"/> Indoor Soccer |
| <input type="checkbox"/> Karate | <input type="checkbox"/> Keystone Club | <input type="checkbox"/> Music Program |
| <input type="checkbox"/> Prevention Programs | <input type="checkbox"/> Science Program | <input type="checkbox"/> Table Tennis |
| <input type="checkbox"/> Technology | <input type="checkbox"/> Torch Club | <input type="checkbox"/> Volleyball |
| <input type="checkbox"/> Weightlifting | <input type="checkbox"/> Wrestling | <input type="checkbox"/> Other |

Disclaimer

I have read the completed application and Parent Handbook, understand the rules, and request that my son/daughter be admitted into membership and has permission to participate in all Club activities. I have explained the rules to my son/daughter and acknowledge that failure to follow said rules may result in suspension or expulsion.

Parent's Signature _____ Child's Signature _____

MEMBERSHIP DESK USE ONLY

Membership Number _____ Entry Date _____ Expiration Date _____
Staff Signature _____

OFFICE USE ONLY

Payment Method Amount Pd \$ _____ Check # _____ Cash Debit/Credit
Payment Entered By _____ Entry Date _____
Debit/Credit Card payments must be made with the Debit/Credit Card Authorization Form



Authorization for the Administration of Medication



In Connecticut, child care programs administering medications to children shall comply with all requirements regarding the Administration of Medications described in the CT State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with the child's name, name of medication, directions for medication's administration, and date of the prescription. All unused medication shall be destroyed if not picked up within one week following the member's departure from the program.

Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):

Name of Child _____ Date of Birth _____ Today's Date _____

Medication Name _____ Controlled Drug? Yes No

Dosage _____ Method _____ Time of Administration _____

Specific Instructions for Administration _____

Medication Administration Start Date ____ / ____ / ____ Stop Date ____ / ____ / ____

Is this medication to be self administered by the child? Yes No

Relevant Side Effects of Medication _____

Plan of Management for Side Effects _____

Known Food or Drug: Allergies Yes No Reactions to Yes No Interactions With Yes No

If "yes" to any of the above, please explain _____

Prescriber's Name _____ Phone Number _____

Prescriber's Address _____ Town _____

Prescriber's Signature _____

Parent/Guardian Authorization

I request that medication be administered to my child as described and directed above.

Program Name: Boys & Girls Club of the Lower Naugatuck Valley Before & After School Program Today's Date _____

Child's Name _____ Address _____ Town _____

Name of Parent/Guardian Authorizing administration of Medication of Medication as described and directed above:

First Name _____ Last Name _____

Relationship to Child Mother Father Guardian/Other (explain) _____

Address _____ Town _____ Phone _____

Signature of Parent/Guardian Authorizing Administration of Medication _____

Name of Program Personnel Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink) _____



Authorization for Self Administration of Medication by Member



Members who need to take prescription or over-the-counter medication must complete an Authorization of Self Administration of Medication form by a parent and physician. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and the date of the prescription. Members must come to the Before/After Care Supervisor, who will keep the medication in a locked box. Members must come to the Supervisor to access their medications. All unused medication will be destroyed if not picked up within one week following the member's departure from the program.

Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):

Name of Child _____ Date of Birth _____ Today's Date _____

Medication Name _____ Controlled Drug? Yes No

Dosage _____ Method _____ Time of Administration _____

Medication Administration _____ Start Date ____ / ____ / ____ Stop Date ____ / ____ / ____

Relevant Side Effects of Medication _____

Plan of Management for Side Effects _____

Known Food or Drug: Allergies Yes No Reactions to Yes No

If "yes" to any of the above, please explain _____

Prescriber's Name _____ Phone Number _____

Prescriber's Address _____ Town _____

Prescriber's Signature _____

Authorization for self administration of medication

I authorize _____ to self administer medication. The member has been taught proper administration of this medicine

Prescriber's Signature _____

Parent/Guardian Authorization for Self Administration of Medication

I request that my child can self medicate as described and directed above

Program Name Boys & Girls Club of the Lower Naugatuck Valley Before & After Care Today's Date _____

Child's Name _____ Address _____ Town _____

Name of Parent/Guardian Authorizing self administration of medication _____

Relationship to Child Mother Father Guardian/Other (explain) _____

Address _____ Town _____ Phone _____

Signature of Parent/Guardian Authorizing Self Administration of Medication _____

Name of Program Personnel Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink) _____