Hawthorne Community Center

HAWTHORNE SCHOOL-AGE
INTAKE AGREEMENT

Parent Initials

_____ 1. I have had explained to me the following policies and I have received a copy of the Parent Handbook which contains these policies. I understand that for my child to be enrolled and attend Hawthorne Community Center. I agree to abide by the policies of the Center. I understand that if I fail to follow the policies, child care services can be terminated. I understand that Hawthorne Community Center sets all policies and procedures based on compliance with state licensing regulations.

_____ 2. I understand the center is open from 6:30 a.m. - 5:45 p.m. Monday through Friday "Except for Major holidays.

_____ 3. I understand my child will only be released to those persons I have named on my "Emergency & Participant Release Form".

_____ 4. I understand the payment and tuition policies of Hawthorne Community Center.

_____ 5. I understand the Discipline Policy and Behavior Management Procedures as presented in the Parent Handdbook and understand the behaviors that will not be allowed by my child.

_____ 6. I understand the following items as presented in the Parent Handbook.

- Late pick up Policy and Fees
- Dress Code
- Safety Policy
- Health Requirements
- Meal Services
- Termination Policies/Withdrawal Policies
- Client Complaint Procedures
- Lice Policy

_____ 7. I understand that my child may be terminated for failure to comply with any of the policies and Procedures listed in the Parent Handbook.

_____ _____
Parent/Guardian Signature Date

_____ _____
Hawthorne Intake Signature Date

HAWTHORNE COMMUNITY CENTER
2440 W. OHIO ST,
INDIANAPOLIS, IN 46222

PHONE (317)637-4312
FAX (317)637-8216

WANDA DIANE ARNOLD, DIRECTOR

United Way
United Way of Central Indiana

HAWTHORNE CHILDCARE REGISTRATION 2012/13
(Please Print)

This registration represents a request for admission. It must be accompanied by a registration fee of $30 which will be returned only if the Center is unable to accept the registration. The registration is not binding. A place will be reserved for the participant when the contract, duly executed, is returned to the Center.

NAME OF PARTICIPANTS	BIRTHDAY	SCHOOL	GRADE
1.			
2.			
3.			
4.			

ADDRESS _____

ZIP CODE _____ HOME TELEPHONE _____ CELL PHONE _____

NAME OF PARENTS/GUARDIANS

FATHER _____

ADDRESS _____

BIRTHDATE _____

EMPLOYMENT/SCHOOL NAME

_____

EMPLOYMENT PHONE NUMBER:_____

MONTHLY GROSS INCOME $ _____

MOTHER _____

ADDRESS _____

BIRTHDATE _____

EMPLOYMENT/SCHOOL NAME

_____

EMPLOYMENT PHONE NUMBER: _____

MONTHLY GROSS INCOME $ _____

CHILD'S PHYSICIAN: _____ PHONE: _____

CHILD'S DENTIST: _____ PHONE: _____

MEDICAL PROBLEMS (Allergies, Physical Limitations, etc.) _____

_____

MEDICAL INSURANCE (check one): ____ MEDICAID ____HOOSIER HELATHWISE ___PRIVATE INSURANCE NO. _____

Does your child receive mental health services? YES or NO IF YES, THEN WHO IS THE MENTAL HEALTH

PROVIDER: _____

DOES YOUR CHILD SEE THE MENTAL HEALTH PROFESSIONAL IN HIS/HER SCHOOL: YES OR NO

I WAS REFERRED TO HAWTHORNE BY: _____

PARENT/GUARDIAN SIGNATURE _____ DATE _____

EMERGENCY AND PARTICIPANT RELEASE FORM
CHILDREN NAMES

1. _____ 2. _____

3. _____ 4. _____

PERSONS WITH LEGAL CUSTODY OF CHILDREN:

I understand that by listing the following names and phone numbers, I hereby give permission to Hawthorne Community Center to release the above mentioned participantes to these persons. I understand that the participants will not be released to anyone not listed on this form for any reasons. I understand that whoever brings or picks up my child, must make sure that the appropriate staff member is aware of their arrival r departure, sign for the child's release and present ID upon request.

MOTHER OR GUARDIAN: FATHER OR GUARDIAN:

Names: _____ Name: _____

OTHER EMERGENCY AND PICK UP CONTACTS OTHER THAN PARENTS/GUARDIANS:

1. _____ _____ _____
NAME PHONE RELATIONSHIP

2. _____ _____ _____
NAME PHONE RELATIONSHIP

3. _____ _____ _____
NAME PHONE RELATIONSHIP

*MEDICAL EMERGENCIES INFORMATION

Permission is herby granted to the Center and its staff to procure medical treatment for the participant in case of injury or accident or otherwise by a doctor, hospital or clinic chosen by the Center, at the expense of the undersigned. This agreement and the rights and duties hereunder my be assigned or delegated, in whole or in part, by either party hereto.

If the emergency is critical, we will send you child to Wishard.

Preferred Hospital: _____ _____
NAME ADDRESS

Physician's Name: _____ _____
NAME ADDRESS

Dentist's Name: _____ _____
NAME ADDRESS

I have read and understand the information required on this form. I understand that it is my responsibility to keep the information on this form current, and that my child my be discharged if I fail to do so.

_____ _____
Parent/Guardian Signature Date