For Office Use Only:
Deposit Paid: _____
Check/Money Order: _____

Montgomery County Schools
District Child Care Program
2017 Summer Camp Application

Student's Name: _____
Last First Middle/Nickname

Mailing Address: _____ DOB: _____ Grade: _____

Full-Time (Mon-Fri.- $100) _____ (or) **Part-Time (3 days or less - $75)**: _____

School: _____Homeroom Teacher: _____

Parent/Guardian's Name: _____

Home Phone #_____Mom's Cell #_____Dad's Cell #_____

Mothers Work #_____Supervisor/Ext: _____Place of Employment_____

Fathers Work # _____ Supervisor/Ext: _____Place of Employment_____

List four other persons who should be contacted in case of an emergency and/or to pick-up your child.
(Aside from parent/guardians, only people listed below will be permitted to pick your child up from the after-school program)

Name: _____ Name: _____

Phone #_____Cell #_____ Phone #_____Cell #_____

Name: _____ Name: _____

Phone #_____Cell #_____ Phone #_____Cell #_____

List other siblings enrolled in the program: _____

Is your child allergic to any medications or foods? **YES** _____**NO** _____ If so, please list_____

_____

List physical handicaps, restrictions, and/or impairments:_____
_____

The Montgomery County School System and/or staff will not be held responsible for any expense or liability incurred by accident or illness beyond that covered by insurance that is carried by the school system. Students, their parents, and employees of the Montgomery County Board of Education are hereby notified this school district does not discriminate on the basis of race, color, national origin, age, religion, marital status, sex or handicap in employment, educational programs, vocational programs, or activities set forth in Title IX, Title VI, & Section 504. Any person having inquiries concerning the above is directed to Richard Culross, Montgomery County Board of Education, 640 Woodford Drive Mt. Sterling, KY 40353/859-497-8760.

CONSENT FOR MEDICAL/SURGICAL CARE/EMERGENCY TREATMENT AND CHILD'S MEDICAL INFORMATION

Name: _____for_____

{ } Mother **{ }** Father **{ }** Legal Guardian **{ }** Son **{ }** Daughter

of____ years of age; hereby voluntarily consent to the rendering of such care, including diagnostic procedures, surgical and medical treatment, and blood transfusions, by authorized members of the hospital staff or their designees, as may in their professional judgment be necessary.

I hereby acknowledge that no guarantees that have been made to me as to the effect of such examination or treatment on child's condition.

We/I hereby give my consent to Montgomery County Schools Child Care Program and After School Programs who will be caring for my child _____ for the period _____to _____ to arrange for routine or emergency medical/surgical/dental care and treatment necessary to preserve the health of my child.

We/I acknowledge that we are (I am) responsible for all reasonable charges in connection with care and treatment rendered during this period.

Name: _____

Address: _____

Phone: _____

Family Physician: _____ Phone: _____

Pediatrician: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Child's Allergies, if any: _____

Medical Conditions, if any: _____

Medications child is taking: _____

****A copy of your child's current up-to-date immunization must be provided to the site-supervisor within 30 days of your child's enrollment.**

I hereby authorize the program to release my child to any of the persons indicated on the contact list as authorized pick-up persons. I have read this form and I certify that I understand its contents.

Signature: _____ Date: _____

Mother, Father, or Legal Guardian

You will receive one free vacation week **per year**. (You will not receive this week during the summer if already used during the school year).
Enter the date you would like to use your free vacation week: _____

(Please let the site supervisor know if changes need to be made.)

CHILD ENROLLMENT FORM/INCOME APPLICATION

1. Participant Information: (To be completed by Parent/Guardian)

If a child is a SNAP/K-TAP recipient or a Kinship/Foster/Head Start participant, the child is automatically eligible to receive free Program meal benefits, subject to the requirements of 7 CFR 226.23.

If your participant receives assistance from the items below, they are automatically eligible for free meals. (Please complete and skip to section 3.)

Participant's Last Name	Participant's First Name	Date of Birth	Normal Typical Hours of Care	Normal/Typical Days of Care (Circle all that apply)	Meals Normally Eaten (Circle all that apply)	Snap or K-TAP # (List Entire Number Below)	Kinship	Foster
			-	M T W Th F Sa Su	B AM L PM S LN		☐	☐
			-	M T W Th F Sa Su	B AM L PM S LN		☐	☐
			-	M T W Th F Sa Su	B AM L PM S LN		☐	☐
			-	M T W Th F Sa Su	B AM L PM S LN		☐	☐
			-	M T W Th F Sa Su	B AM L PM S LN		☐	☐

***Parent/Guardian works multiple shifts and participants may be in care different days/hours ____yes ____no**

2. Income Application Household Members and Monthly Income:

NAMES OF HOUSEHOLD MEMBERS Including Children Not Listed Above **Last, First**	**GROSS MONTHLY** Income From Work (Before Deductions)	**MONTHLY** Income From Welfare Payments, Child Support, Alimony	**MONTHLY** Income From Pensions, Retirement, Social Security, Unemployment Compensation	Any Other **MONTHLY** Income Including Money Received from Kinship/Foster Child
1.	**$**	**$**	**$**	**$**
2.	**$**	**$**	**$**	**$**
3.	**$**	**$**	**$**	**$**
4.	**$**	**$**	**$**	**$**
5.	**$**	**$**	**$**	**$**

3. Signature and Social Security Number:

I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.

X_____ _____

Signature of Adult Household Member **Home/Cell Phone Number**

X_____ ☐ No Social Security Number X_____

Last four digits Social Security Number* **Date**

FOR SPONSOR USE ONLY. DO NOT WRITE BELOW THIS LINE.

Application approved for:

☐ Free Meals

☐ Reduced Price Meals

☐ Paid

☐ SNAP/KTAP

☐ Foster/Kinship

☐ Income Household

Total Household Monthly Income_____

Household Size_____

_____

Signature of Determining Official

_____

Date

**7 CFR 226.15 (e)(2)*

"The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The last four digits of the Social Security Number are not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program."