



**2018 Summer Camp  
APPLICATION PACKET**

**FOR**

**Bayfield Early Education Programs, Inc.**

645 Fox Farm Circle  
P.O. Box 1584  
Bayfield, CO 81122

Phone: 970-884-7137  
Fax: 970-884-2960  
beepprograms@qwestoffice.net  
www.beepreschool.org

**Session 1**  
June 4 to June 28 (4 weeks)

**Session 2**  
July 9 to Aug 2 (4 weeks)

**EXECUTIVE DIRECTOR:** Joe Poynter  
**ADMINISTRATIVE ASSISTANT:** Andrea Foutz

<b>Child's Name:</b> _____			
<b>For Office Use Only:</b>		<b>M</b>	<b>F</b>
<b>Schedule</b>			
<b>Session</b>			
<b>Appl Fee</b>			
<b>Date Rec'd</b>			
<b>Records Rec'd</b>	Well Child	Immunizations	Participate

# SUMMER FUN!

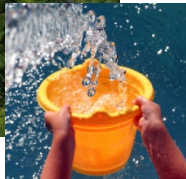
We have lots of fun during BEEP summer camps.



We learn through themes of Bugs, camping, gardening, and more.



Every day we work on crafts, sing songs, and read stories. We also walk to nearby parks and do water play on our playground.



Sometimes we see Smokey Bear and do things with the Pine River Library.



It is fun to plant the garden and watch it grow.

Even though we are busy, we take time to rest every day.

Pack a lunch, water bottle, and towel (for water play). Leave a change of clothes with us and apply sunscreen before you drop off. PLEASE no flip flops!

*We look forward to seeing you at BEEP Summer Camp!*

**Bayfield Early Education Programs, Inc.**  
**IDENTIFICATION AND**  
**EMERGENCY INFORMATION**

Name of Child: \_\_\_\_\_

Last

First

Middle

Date of Birth: \_\_\_\_\_

M

F

Physical Address: \_\_\_\_\_ Zip: \_\_\_\_\_

City

State

Mailing Address: \_\_\_\_\_ Zip: \_\_\_\_\_

City

State

Phone # \_\_\_\_\_ Preferred Email Address: \_\_\_\_\_

**Mother or guardian:** \_\_\_\_\_

Physical Address: \_\_\_\_\_ Zip: \_\_\_\_\_

City

State

Mailing Address: \_\_\_\_\_ Zip: \_\_\_\_\_

City

State

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ SS#: \_\_\_\_\_

Employment/School: \_\_\_\_\_ Phone: \_\_\_\_\_

Work Email Address (if any): \_\_\_\_\_

**Father or guardian:** \_\_\_\_\_

Physical Address: \_\_\_\_\_ Zip: \_\_\_\_\_

City

State

Mailing Address: \_\_\_\_\_ Zip: \_\_\_\_\_

City

State

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ SS#: \_\_\_\_\_

Employment/School: \_\_\_\_\_ Phone: \_\_\_\_\_

Work Email Address (if any): \_\_\_\_\_

**Persons authorized to pick up child:** (list yourself) (must be 18 years old):

Name	Phone	Name	Phone

If applicable:

Custody arrangements: (Please indicate where child will be)

Monday night \_\_\_\_\_

Thursday night \_\_\_\_\_

Tuesday night \_\_\_\_\_

Friday night \_\_\_\_\_

Wednesday night \_\_\_\_\_

Weekend \_\_\_\_\_

**Under no circumstances will child be released to anyone not known to the school without authorization from parent(s) or guardian(s).**

*Note: It is legal for either parent to pick up a child unless we have a copy of a court order restricting visitation.*

**List persons to be called in case of emergency, IN CASE PARENTS CANNOT BE REACHED:**

(Be sure to include someone other than yourself who will usually know your whereabouts.)

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Child's physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Child's dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Emergency hospital preference: \_\_\_\_\_

# Bayfield Early Education Programs, Inc.

## HEALTH HISTORY (MUST BE COMPLETED!!)

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**ALLERGIES** (Food, insects, medicines, etc.) Please explain severity and symptoms:

- |     |   |     |    |
|-----|---|-----|----|
| 1.  | Is your child in good health at this time?<br>If no, please explain   | Yes | No |
| 2.  | Is your child generally healthy most of the time?<br>If no, please explain  | Yes | No |
| 3.  | Does your child tolerate normal exercise?   | Yes | No |
| 4.  | Do any siblings have a health problem?<br>If yes, please explain  | Yes | No |
| 5.  | Does your child have difficulty hearing?  | Yes | No |
| 8.  | Has your child ever had wheezing or asthma?   | Yes | No |
| 13. | Does your child have problems with diarrhea or constipation?  | Yes | No |
| 21. | Has your child been under a physician's care in the last 12 months?<br>If yes, please explain                         | Yes | No |
| 22. | Does your child have to limit his/her activities for health reasons?<br>If yes, how & why                             | Yes | No |
| 23. | Does your child have trouble sleeping?  | Yes | No |
| 24. | Are there any problems with his/her teeth?  | Yes | No |
| 25. | Is your child taking medicine now?<br>Is this for long-term medication administration?<br>If yes, contact the office. | Yes | No |

***Your child must be potty trained!!***

# Bayfield Early Education Programs, Inc.

## PERMISSION TO PARTICIPATE IN SCHOOL ACTIVITIES AND TO RECEIVE EMERGENCY MEDICAL CARE

I hereby grant permission for my child, \_\_\_\_\_, to use all of the play equipment and participate in all of the activities of the school and to leave the school premises under the supervision of a staff member for neighborhood walks or for field trips.

I hereby grant permission for the Director or Acting Director to take whatever steps may be necessary to obtain emergency medical care. These steps may include, but are not limited to, the following:

1. Attempt to contact a parent or guardian, the child's physician, or the persons listed on the emergency information form.
2. If we cannot contact you or your child's physician we will do one or both of the following: (a) call another physician or paramedics (b) have the child taken to an emergency hospital in the company of a staff member.
3. Any expenses incurred under two (2) above will be borne by the child's family.
4. The school will not be responsible for anything that may happen as a result of false information given at the time of enrollment.
5. The school WILL NOT assume responsibility for a child who has not been signed in upon arrival for the day.

*Both parents must sign below.*

Signed \_\_\_\_\_ (Mother or Legal Guardian) Date \_\_\_\_\_

Signed \_\_\_\_\_ (Father or Legal Guardian) Date \_\_\_\_\_

**Bayfield Early Education Programs, Inc.**

**SUNSCREEN APPLICATION**

As the parent/guardian I recognize that too much sunlight may increase my child’s risk of getting skin cancer someday. Therefore, I give my permission for BEEP teachers and staff to apply sunscreen when my child will be playing outside. I understand that sunscreen may be applied to exposed skin, including but not limited to face, tops of ears, nose, bare shoulders, arms, and legs.

As with any topical medication or cream, the first application of any brand of sunscreen should be applied at home in order to evaluate your child’s possible allergic reaction to that product.

I will provide sunscreen for my child, \_\_\_\_\_ (name). I will label the bottle with my child’s name and personally hand it to my child’s teacher.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MOVIE/VIDEO RELEASE FORM**

Although movies and videos are not part of BEEP’s learning environment, occasionally “G” rated movies and videos are shown. This may happen when recess is not advised due to weather conditions.

I consent to my child \_\_\_\_\_ (name) watching a “G” rated movie/video when recess is not advised due to weather conditions.

Signature of Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_

**NOTICE OF NON-DISCRIMINATORY POLICY**

Bayfield Early Education Programs, Inc. admits students of any race, color, gender, national and ethnic origin to all the rights, privileges, programs, and activities generally accorded or made available to students at the school. It does not discriminate on the basis of race, color, gender, national and ethnic origin in administration of its educational policies, admissions policies, scholarship and loan programs, and athletic and other school-administered programs.

**Bayfield Early Education Programs, Inc**  
**Hours of Operation and Fee Schedule**  
**Summer 2018**

**TUITION INFORMATION** for \_\_\_\_\_

Child's Name

**Summer  
Application  
Fee:**

**\$35.00** *Nonrefundable. Must accompany application to have application accepted.*

**\$30.00** *Nonrefundable for preschoolers who attended the 2017-2018 school year.*

**(circle all that apply)**

**Session 1**  
**June 4 to June 28**

**Session 2**  
**July 9 to Aug 2**

**Days of Operation:**

Monday   Tuesday   Wednesday   Thursday  
(circle all that apply – 2 day minimum required)

**Opening Time:**

7:45am

**Summer Day:**

8:00am – 5:00pm

**TUITION DISCLOSURE**

**Tuition is due the first day of each month.** A late fee of \$20.00 will be added to tuition not paid by the 15th day of the month; another late fee of \$20 can be imposed on the 30<sup>th</sup> if tuition is still overdue. If tuition is 30+ days overdue, your child may be asked to leave the program and your account balance may be assigned to a collection agency. For your convenience, we accept cash, check, Mastercard, Visa, and Discover. We can also set up your account for recurring payments.

Late pickup fee after 5:00pm is \$25 per quarter hour rounded up to the nearest quarter hour. At 5:30pm, the Marshal's office will be notified.

**Due to staffing regulations, IT IS IMPORTANT THAT CHILDREN ARE PICKED UP PROMPTLY**

***If it is necessary for you to withdraw your child from the program, the school must receive a two weeks written notice prior to leaving. Otherwise, tuition payment for the two weeks is required.***

*All children attending Summer Camp must rest in a specified classroom and parent must provide their child with a nutritious lunch and water bottle. Please no soda pop style beverages or candy.*



# Bayfield Early Education Programs, Inc.

## Tuition

**Session 1:** Number of Days \_\_\_\_\_ X \$38/ day

**Session 2:** Number of Days \_\_\_\_\_ X \$38/ day

**TOTAL ESTIMATED TUITION PER Session 1:** \_\_\_\_\_ **Session 2:** \_\_\_\_\_

I, \_\_\_\_\_ understand, as the parent/guardian of \_\_\_\_\_, that tuition is due on or before the 1st day of the month. A late fee of \$20.00 will be added to tuition not paid by the 15th day of the month; another late fee of \$20 can be imposed on the 30<sup>th</sup> if tuition is still overdue. If tuition is 30+ days overdue, your child may be asked to leave the program and your account balance may be assigned to a collection agency. For your convenience, we accept cash, check, Mastercard, Visa, and Discover. We can also set up your account for automatic payments.

A \$15 nonsufficient funds fee is assessed for those payments that are returned as NSF (for checks) or DECLINED (for credit cards).

Signature of  
Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Mother

Social Security Number (required) \_\_\_\_\_

Mother

Signature of  
Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Father

Social Security Number (required) \_\_\_\_\_

Father

### HEALTH RECORDS

Please submit with your application a copy of your child's most current health appraisal and immunization record. Colorado law requires that BEEP have these documents on file before your child can attend our program.

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**CHILD'S STATEMENT OF HEALTH STATUS FOR ENROLLMENT IN A CHILD CARE FACILITY**

The child care facility must obtain for every child who enrolls in child care programs a signed and dated statement of the child's current health status which indicates the child's abilities and/or limitations to participate in a regularly scheduled child care program. This report is to be filled out by a licensed physician or other health care professional who has seen the child. Health appraisal forms are to be done on a yearly basis according to AAP recommendations.

*This form to be completed by your doctor!!  
You enter the name and date of birth!*

Name of Facility: **Bayfield Early Education Programs, Inc.** Type of Facility: Preschool

Child's Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Past Illnesses - check those the child has had and give approximate dates:

Chicken Pox _____	Roseola _____	Rubella _____
Rheumatic Fever _____	Asthma _____	Hay Fever _____
Diabetes _____	Mumps _____	Epilepsy _____
Whooping Cough _____	Poliomyelitis _____	Other _____

Comments: \_\_\_\_\_

Surgery/Accidents/Illnesses/Chronic Health Problems: \_\_\_\_\_

Describe any physical condition requiring the facility's special attention: \_\_\_\_\_

Are you currently taking any medications? \_\_\_\_\_

Allergies:

Food \_\_\_\_\_ Reaction \_\_\_\_\_

Drug \_\_\_\_\_ Reaction \_\_\_\_\_

If chest x-ray taken: Date: \_\_\_\_\_ Result: \_\_\_\_\_

Vision: \_\_\_\_\_ Hearing: \_\_\_\_\_

**Please record immunizations and dates administered on the Colorado Department of Health Certificate of Immunization and attach to this form.**

Immunizations given today: \_\_\_\_\_

Date of my most recent examination of the child: \_\_\_\_\_ Date of next scheduled exam \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Signature of licensed physician or other health care professional \_\_\_\_\_ Date \_\_\_\_\_

Please Print:

<b>Doctor:</b>		<b>Clinic:</b>	
<b>City:</b>	<b>State:</b>	<b>Zip:</b>	<b>Phone:</b>