



Interventions Unlimited, Inc. Tel: 407-678-8889, Fax: 407-678-8885
Email: info@interventionsunlimited.com Website: www.interventionsunlimited.com

2008-2009 AFTER SCHOOL PROGRAM POLICIES

Dear Parent/Guardian,

Thank you for your interest in our After School Program(s). Please review the following policies and complete all the enclosed forms in your application packet. Please note that the application does not guarantee acceptance of your child into the program. It is our intent to provide a positive learning experience while maintaining the safety of all children and staff. For this reason, some children may be accepted on a trial basis. Space is limited, and we encourage you to apply at your earliest convenience.

After we receive your application, we will notify you of your child's acceptance. We look forward to the prospect of meeting you and having your child with us this coming school year. In the mean time, if you have any questions or concerns, please contact us.

Schedule

Our After School Program will start on August 18, 2008. The time is from 2:00 pm to 6:00 pm. Your child can be dropped off or picked up any time during this period.

Payment

The \$40.00 application fee is nonrefundable.

At the time of application, tuition payment is required in full for the rest of Aug. (2 weeks).

A full refund of paid tuition will be issued if your child is not accepted into the program.

Children who are accepted on a trial basis will be refunded the remaining tuition balance if he or she is dismissed from the program.

50% of the paid tuition will be refunded if the child is dismissed from the program due to health and behavioral issues that are not disclosed in the application.

Your credit card will be billed automatically at the end of each month for the following month's participation in the program.

Cancellation

50% of your tuition payment for the first month will be refunded if a written request of cancellation is received by Aug. 11. 2008.

Participation is required on a monthly basis. We will bill your credit card automatically at the end of each month. A written request of cancellation is required at least one week prior to the cancellation of participation for the following month.

Sick Policy

Your child will be sent home if he or she has any of the symptoms below. For the well being of all the program staff and other children, please keep your child at home if he or she has any of the following Symptoms:

- 1) A fever of 102 or higher. If you child has had a fever. He or she must be fever free for 24 hours before returning to the After School Program.
- 2) Vomiting
- 3) Visible mucus (green/yellow)
- 4) Conjunctivitis (pink eye)
- 5) Diarrhea
- 6) Cough that has lasted more than 5 days.
- 7) Head Lice

Pick up

Your child must be picked up at the allotted time. A late fee of \$5 will be incurred for every 5 minutes that the parent/guardian is late.

Supplies

Parents are responsible for supplying the snacks, drinks, extra change of clothes, diapers, pull ups and wipes for your child. Please label everything with your child's name.

I have reviewed the above policy and hereby give my consent for my child _____ to participate in the After School Program.

Child's name

Parent/Guardian Signature



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AFTER SCHOOL PROGRAM APPLICATION

On behalf of my son() daughter() _____ / _____
(first or given name) (last or family name)

I wish to apply for admission to Interventions Unlimited Inc.'s 2008-2009 After School Program.

I attest that to the best of my knowledge, the information provided on the application is accurate.

Parent Signature: _____

Background Information:

Child's Name: _____

S.S. # _____ Date of Birth: _____

Present School Grade _____ Name of the School _____

Father's Name: _____

Home Address: _____

Home Telephone: (_____) _____ Cell phone: (_____) _____

Email: _____

Mother's Name: _____

Home Address: _____

Home Telephone: (_____) _____ Cell phone: (_____) _____

Email: _____

With whom does the child live with? _____

Emergency contact: _____

Please list the name(s) of individuals authorized to pick up your child:

Name _____ Relationship _____

Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

Payment

Please find enclosed check in the amount of: \$ _____
I would like the amount of \$ _____ to be charged to my credit card account:
Visa/Master card # _____ Exp. Date: _____ 20 _____
Name as It Appears On the Card: _____

Card Holder Signature _____ Date _____

Does your child have a medical diagnosis? Yes _____ No _____

If yes, what diagnosis? _____ Diagnosed By: _____

Age at Diagnosis: _____

Behavior: Does your child engage in the following behaviors?

Non compliance: _____ Yes _____ No

Frequency _____ Duration _____ Intensity _____

Tantrum: _____ Yes _____ No

Frequency _____ Duration _____ Intensity _____

Aggression: _____ Yes _____ No

Frequency _____ Duration _____ Intensity _____

Running Away: _____ Yes _____ No

Frequency _____ Duration _____ Intensity _____

Self Injurious Behaviors: _____ Yes _____ No

Frequency _____ Duration _____ Intensity _____

Stereotypical Behaviors (hand flapping, flicking, toe walking, rocking, twirling, etc.)

_____ Yes _____ No

Frequency _____ Duration _____ Intensity _____

Other behaviors not listed above: _____

Frequency _____ Duration _____ Intensity _____

Repeat previously heard words: _____ Yes _____ No

Difficult with transitions or changes in routine: _____ Yes _____ No

Unusual interest in the sight, feel, sound or smell of things: ____ Yes ____ No

Unusual preoccupations/obsession: ____ Yes ____ No

Verbalizing in a repetitive manner: ____ Yes ____ No

Communication:

1. What are the primary ways the child communicates with other people?

2. On the following chart, please indicate the behaviors the child uses to achieve the communicative outcomes listed:

Communicative Functions	Complex speech	Multiple-word phrases	One-word utterances	Echolalia	Other verbalization	Complex signing	Single signs	Pointing	Leading	Shakes head	Grabs/reaches	Gives objects	Increased movement	Moves close to you	Moves away or leaves	Fixed gaze	Facial expression	Aggression	Self-injury	Other
Request attention																				
Request help																				
Request preferred Food/objects/activities																				
Request break																				
Show you something or some place																				
Indicate physical pain																				
Indicate confusion or unhappiness																				
Protest or reject a Situation or activity																				

3. Does the child follow spoken requests or instructions? If so, approximately how many?

4. Does the child respond to signed or gestural requests or instructions? If so, how many?

5. Can the child imitate sounds, words, or phrases? If so, what are they?

6. How does the child indicate “yes” or “no” when asked if she/he wants something, or wants to go somewhere?

Self Help Skills:

Please list the child’s current level of functioning on the following skills:

Toileting _____

Feeding: _____

Dressing: _____

Grooming: _____

NOTE: we accept children who have bladder and/or bowel control difficulties, but would appreciate the following information in order to insure proper care.

Does your child wet___ or soil___ during the day? Yes___ No___

Do you use Pull-Ups, diapers etc... at home ? Yes___ No___

If “Yes” please describe: _____

IMPORTANT: For health and sanitary reasons, children who are not toilet trained must wear protective undergarments.

Reinforcers:

Please list the things that the child likes:

1. Food: _____

2. Objects: _____

3. Activities: _____

4. Other: _____

Educational Background (only applies to school age children):

Does your child attend school? _____ yes _____ no

What type of classroom is your child currently enrolled in?

How long has your child been attending school? _____

Goals and Objectives:

Please list some goals that you would like your child to achieve by participating in the After School Program.



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2008-2009 After School Program Health Information
(To be completed by parent/guardian)

Child's Name: _____ DOB: _____ Age: _____

Male _____ Female _____ Height: _____ in. Weight: _____ lbs.

In case of illness or emergency, please contact: _____

Address _____

Street number

City

Zip Code

Phone: _____ Cell Phone: _____

Heath History

(Check all that apply)

___ Chicken Pox

___ Measles

___ Epilepsy

___ Hepatitis

___ Kidney disease

___ Asthma

___ Mumps

___ Heart conditions

___ Diabetes

___ Ear infections

___ Enuresis (bed wetting)

___ Conduct Disorders

___ Severe stomach aches

___ Sun sensitivity

If you checked any of the above please explain in detail:

Please be specific in answering the following:

Does your child have physical restrictions/limitations? ___ Yes ___ No

If yes, explain:

Does your child suffer from any allergic reactions to:

Penicillin: _____ Other drugs: _____ Bee or wasp sting: _____ Foods: _____

Others: _____

Please specify which foods he/she is allergic too:

Any dietary restrictions? ___Yes ___No

If yes, explain:

Is your child currently taking medications? ___Yes ___No

- **If yes, please be sure to fill out the medication release form.**

IN CASE OF EMERGENCY

Your child's physicians full name: _____

Address: _____
Street Number City Zip Code

Phone Number: _____

I hereby attest that to the best of my knowledge, the child named above is in good health and physically and mentally able to participate in all program activities, except as previously noted. In case of a medical emergency, in which I cannot be contacted, I hereby give permission to Interventions Unlimited, Inc. to seek proper medical treatment for the child named above.

Parent/guardian: _____

Date: _____



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2008-2009 After School Program

Medication Administration Form

For Medications Supplied by Parents

I _____, give permission for my child _____, to have his or her oral medication(s) administered to him or her during the school hours by an Interventions Unlimited, Inc. school staff.

My child will need the following medication (s) and dosage (s) administered during the school hours:

Medication	Dosage	Time
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Instructions for administering the medication(s):

Signed: _____ Date: _____

PHYSICIAN signature required for ALL PRESCRIPTION medications

Signed: _____ Date: _____

PARENT signature required for prescription and over-the-counter medications

Medication must be provided in its original container from the pharmacy with dosage amount, directions, and the name of the prescribing physician. Please note that if the above information is not provided the medication will not be administered.



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2008-2009 After School Program Release Forms

Photo and Video Taping Release

I hereby give consent for photography and video taping of my child that will only be used by Interventions Unlimited, Inc. for educational, promotional, or other proper purposes only.

Parent/Guardian Signature: _____ Date: _____

Liability Release

I acknowledge that my child has been accepted and permitted to participate in the After School Program. I hereby release, discharge, and waive Interventions Unlimited, Inc. and its employees from all liability for injuries, loss or damages, and any claims for damage on account of any injuries to my child or his or her property while in the After School Program. I have agreed to emergency treatment by a physician or hospital in the event that I cannot be reached. I have disclosed all relevant information regarding my child's health condition.

Parent/Guardian Signature: _____ Date: _____