



AHWATUKEE FOOTHILLS PREP – OASIS

In order to continue to the enrollment process you will need to provide the following documents and \$20 registration fee (\$10 for each additional child).

Items Included in this packet to be submitted:

- Program Schedule and Prices (**keep for your own records**)
- Emergency Contact Information (2 pages total). Please provide all the information.
- Parental Payment & Policy Agreement
- Medical information and Authorization

Copies of other essential documents that must be submitted:

- Immunization Record (must be attach to emergency form, if not application will not be accepted)

Additional documents to be submitted ONLY if they apply to your child:

- IEP *if applicable*
- Custody Papers

Failure to complete and return enrollment forms with registration fee may cause your student to lose their position in OASIS!

If you have any questions regarding this procedure or need assistance completing the forms please contact cbanks@afprep.org

Sincerely,

Cheryl Banks

OASIS Director

OASIS Program Schedule and Prices

602-696-5895 Direct Line

Morning Program:

6:00 AM – 7:45 AM (\$7.00 per day)

6:00 - 7:30 AM	Child Initiated Social Time
7:30 - 7:45 AM	Breakfast Snack
7:45 AM	Dismissal

Afternoon Program Schedule:

3:30-6:00 PM (\$10.00 per day)

3:30 - 4:15 PM	Snack, Child Initiated Social Time
4:15 - 4:45 PM	Indoor Play
4:45 - 5:45 PM	Tutoring and Homework
5:45 - 6:00 PM	Individual Time
6:00 PM	Dismissal

Half-Day Program Schedule:

1:00 - 6:00pm (\$18.00 per day) before 3:30pm \$10.00 per day

1:00 - 2:15 PM	Attendance, Child Initiated Time
2:15 - 4:15 PM	Homework, Tutoring
4:15 - 5:00 PM	Snack, Child Initiated Time
5:00 - 5:45 PM	Outdoor Play
5:45 - 6:00 PM	Free Time, Dismissal

Full-Day Program Schedule:

6:00 - 6:00 PM (\$35.00 per day)

6:00 - 7:15 AM	Attendance, Child Initiated Time
7:15 - 8:00 AM	Breakfast, Child Initiated Time
8:00 - 8:45 AM	Educational Games
8:45 - 9:30 AM	Outdoor Play
9:30 - 10:15 AM	Music/Art
10:15 - 11:45 AM	Tutoring
11:45 - 12:30 PM	Parent provided Lunch, Child Initiated Time
12:30 - 1:15 PM	Science Activities
1:15 - 2:00 PM	Monthly Ed Focus
2:00 - 2:45 PM	Outdoor Play
2:45 - 3:30 PM	Music/Art
3:30 - 4:15 PM	Educational Games
4:15 - 5:00 PM	Snack, Child Initiated Time
5:00 - 5:45 PM	Outdoor Play
5:45 - 6:00 PM	Free Time, Dismissal

Emergency Information and Immunization Record Card

Child's Name: _____

Date Enrolled: _____ Updated: _____

Home Address: _____
Street City State Zip

Date Disenrolled: _____

Home Phone: _____

Date of Birth: _____ Sex: male female

Mother or Guardian Name: _____	
Home Address: _____ <small>Street City State Zip</small>	
Home Phone: _____	Cell Phone: _____
Business Name: _____	Work Phone: _____
Business Address: _____ <small>Street City State Zip</small>	
Signature: _____	

Father or Guardian Name: _____	
Home Address: _____ <small>Street City State Zip</small>	
Home Phone: _____	Cell Phone: _____
Business Name: _____	Work Phone: _____
Business Address: _____ <small>Street City State Zip</small>	
Signature: _____	

If Medical Care is Necessary, Call:

DOCTOR: _____
Name Address City State Zip Phone

HOSPITAL: _____
Name Address City State Zip Phone

Does your child have insurance coverage? No Yes
 Name of Insurance Company _____ (Optional)

In case of injury or sudden illness, _____ will be called first. I hereby give authority to any hospital or doctor to render immediate aid as might be required at the time for his/her health and safety. It is understood by me that the expense of this service will be accepted by me.

In case of an emergency, or if I cannot be contacted to pick up my child, I hereby authorize the following person(s) to pick up my child.

Name: _____ Name: _____

Address: _____ Address: _____
Street City State Zip Street City State Zip

Telephone: _____ Cell phone: _____ Telephone: _____ Cell phone: _____

Name: _____ Name: _____

Address: _____ Address: _____
Street City State Zip Street City State Zip

Telephone: _____ Cell phone: _____ Telephone: _____ Cell phone: _____

The following person(s) may **not** remove my child from the center:

Name: _____ Name: _____

Custody papers have been provided and are on file at the facility. yes no

This Emergency Information and Immunization Record Card is accurate and complete, front and back, and was provided by:

Parent or Guardian printed name _____ Signature _____ Date: _____

Immunization Information

Age	Required Vaccine Doses By Age						
	DTaP	Polio	Hib	Hepatitis B	Hepatitis A	MMR	Varicella
<2 months				#1			
2 - 3 months	#1	#1	#1				
4 - 5 months	#2	#2	#2	#2			
6 - 11 months	#3		#2 - #3 ¹				
12 - 14 months		#3	#1 - #4 ²	#3		#1	#1
15 - 59 months	#4						
24 - 71 months					#1 ³ & #2 ³		
School Age (K-12)	#4 ⁴ or #5	#3 ⁵ or #4		#3		#2 ⁶	#1 ⁷

¹ Pedvax or Comvax vaccine given

² Must have at least 1 Hib after 12 months of age

³ Hep A required in Maricopa County only

⁴ 4 doses meet requirement if 4th dose is after 4th birthday

⁵ 3 doses meet requirement if 3rd dose is after 4th birthday

⁶ Must have 2 doses of MMR for K-12 entry

⁷ A 2nd dose is needed if dose #1 is given at 13+ years of age

Check one

<input type="checkbox"/>	Copy of current official documented immunization record attached. <i>(Must be attached)</i>
<input type="checkbox"/>	Religious Beliefs exemption form signed by parent/guardian attached
<input type="checkbox"/>	Medical Exemption form signed by physician and parent/guardian attached
<input type="checkbox"/>	Signed Laboratory Proof of Immunity form attached

Notification of immunizations needed sent to Parent(s) or Guardian(s):

____/____/____
MO /DAY/ YR

____/____/____
MO /DAY/ YR

____/____/____
MO /DAY/ YR

Updated immunizations received and attached

____/____/____
MO /DAY/ YR

____/____/____
MO /DAY/ YR

____/____/____
MO /DAY/ YR

Medical Information

Is child allergic to food or other substances? No Yes (If yes, name foods or substances to be avoided and procedure to follow if reaction occurs.) _____

Is child usually susceptible to infections and if so, what precautions need to be taken? No Yes _____

Is child subject to convulsions and what should be our procedure if one occurs? No Yes _____

Is there any physical condition that we should be aware of and what precautions should be taken (heart trouble, foot problem, hearing impairment, hernia, etc.)? No Yes _____

Additional comments: _____

Other special instructions: _____

Telephone Authorization Code : _____ (optional)

OASIS Program - Health and Illness Policy

The OASIS program is designed for well childcare.
A certificate of Health and Immunization Record must be on file for each child.

Illness Policy Statement

In an effort to manage and prevent disease spread the OASIS program will follow the prescribed guidelines as stated in **Infections in Children, A Sourcebook for Educators and Child Care Providers**. Exposure to many contagious diseases is a normal part of childhood. The school setting, because of its communal nature, increases the likelihood of exposure. It is expected that parents will cooperate fully with the staff in the event a child must be excluded from the program.

Exclusion Policy

The phone call that informs a busy working parent that they must leave work to pick up sick child is as difficult for the staff to make as it for the parent to receive. OASIS endorses exclusion standards that will help control the occurrence of illness among children, their families, staff and the community. Exclusion standards followed are put forth by the U.S. Department of Health and Human Services, Public Health Service and the Centers for Disease Control. This policy ultimately protects other children and staff members and recognizes the limitations of staff capabilities to adequately care for a sick child.

Your child must not attend the OASIS program if exhibiting any of the following symptoms:

- A temperature of 100 degrees or higher
- Intestinal disturbance accompanied by diarrhea or vomiting
- Severe itching and scratching of the body or scalp (head lice, scabies, etc.)
- Any disease that is classified as reportable, i.e. disease that have special implications for public health due to their high communicability or seriousness.

Illness Management

If your child develops any of the above symptoms while attending the OASIS program, the staff will help your child rest comfortably in an area away from the other children. You will be promptly contacted to arrange pickup for your child within one hour.

Administration of Medicine

Should your child require any medication prescription or over the counter, while in our care, the staff will only be able to administer it when the following conditions are met:

- If state licensing requirements permit the administration of medicine
- The parent provide a written request, with specific instructions, for the staff member to administer the medication
- The medication is in its original packaging and dispensed with the child's name, name of the drug, and directions for administration
- Medication will be administered according to the directions on the label. Any variance will require written authorization from a physician. Unless physician's instructions indicate otherwise, medication can be given for a period not exceeding two weeks.

All medications are stored in locked containers or in a refrigerator inaccessible to children. Please do not send medicine, including vitamins, cough drops, or any other item of that nature in your child's back pack. All medicines are to be handed directly to the appropriate staff member.

Acknowledgement

I have read and understand the OASIS Program Health and Illness Policy and agree to abide by the terms outlined.

Signature of Parent or Legal Guardian

Date

Signature of Program Director

Date

OASIS Program - Medical Information and Authorization

(One Per Child)

Name of Child _____ Date of Birth _____

Child's Physician _____ Telephone# _____

Parents
Initials

I am aware that the state law requires that all children attending a childcare facility be in good health, free of communicable diseases and current with all required immunizations. I agree to complete my portion of the Certificate of Health & Immunization Form and have this form signed by my child's physician prior to my child's enrollment date.

Before any medication is dispensed to my child, I will provide a written authorization which includes: date; name of child; name of medication; prescription number, if any; dosage; any potential adverse reactions; date and time of day medication is to be given. Medicine will be in the original container with my child's name marked on it. * Medicine will be administered if permitted by state regulations.

Should my child suffer an injury or illness while in the care of the OASIS program, I hereby grant the OASIS staff permission to take whatever action in its judgment may be necessary in supplying emergency medical services. I understand that, consistent with the circumstances of the situation I will be contracted in my instructions followed or the instructions of any other designated emergency contact or me. I hereby grant permission to the OASIS program staff to contact and comply with the advice of an available physician, ambulance personnel, or emergency room personnel. I hereby agree that I will be solely responsible for and will promptly pay any expenses incurred by the program in making emergency medical care available to my child. I also understand and agree that my insurance will act as the primary coverage.

In an effort to anticipate and be prepared for any medical emergency involving a child, the OASIS program has contacted the closest medical center to pre-arrange for emergency treatment. The procedure in case of an emergency will be to first advise the parent or guardian (given time is available), and then proceed directly to the closest medical center by emergency vehicle.

I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur; e.g. telephone numbers, work location, emergency contacts, child's physician, child's health status, immunization records, etc.

I have received and agree to abide by the Illness and Exclusion Policy for the OASIS program.

Received and reviewed by: _____
OASIS Program Director _____ Date _____