SAMENA

• SWIM & RECREATION CLUB •

BEFORE & AFTER SCHOOL CARE

Registration Packet

2017/2018

All forms are due in completion at time of registration.

Samena Swim and Recreation Club
15231 Lake Hills Blvd. Bellevue, WA 98007
Phone: **(425) 746-1160** Fax: **(425) 746-4485**
www.samena.com
Program Director: Kristen Parkin, ext. 117
Program Coordinator: Jason Menia, ext.128

2017-2018 Samena Before & After School Tuition

5 Day Monthly	Members Rate	Non-Member Rate
Before School Only	$310	$400
2nd child	$250	$315
3rd child	$145	$195
Afterschool Only	$525	$620
2nd child	$405	$490
3rd child	$260	$305
Before & After	$610	$720
2nd child	$490	$590
3rd child	$325	$375

4 Day Monthly	Members Rate	Non-Member Rate
Before School Only	$280	$335
2nd child	$225	$280
3rd child	$135	$165
Afterschool Only	$455	$555
2nd child	$360	$440
3rd child	$230	$285
Before & After	$560	$665
2nd child	$450	$520
3rd child	$290	$335

3 Day Monthly	Members Rate	Non-Member Rate
Before School Only	$225	$295
2nd child	$170	$225
3rd child	$120	$160
Afterschool Only	$395	$490
2nd child	$315	$395
3rd child	$205	$250
Before & After	$475	$595
2nd child	$380	$485
3rd child	$245	$250

2 Day Monthly	Members Rate	Non-Member Rate
Before School Only	$160	$205
2nd child	$130	$170
3rd child	$90	$105
Afterschool Only	$350	$430
2nd child	$285	$335
3rd child	$180	$215
Before & After	$415	$510
2nd child	$335	$425
3rd child	$215	$260

2017-2018 Samena Before & Afterschool Registration Form

Child's Name_____M____F____Birthdate_____Age_____

Child's School_____ Grade_____

Club Member?: _____

Parents'/Guardians Name _____ Best Phone #_____

_____ Best Phone#_____

Home Address _____Zip_____

Phone_____

Email_____

Any known allergies or medical conditions? ____ If yes, explain:_____

Family doctor: _____ Phone: _____

Date of Last Physical_____

Family Dentist:_____Phone:_____

Date of Last Dental Exam _____

Emergency Contact: _____Relation: _____

Phone: _____

Authorized person(s) to pick up my child other than guardians:

Name: _____ Day Phone: _____

Name: _____ Day Phone: _____

Has your child had previous swim instruction? _____ If yes, please explain:_____

How many days are you registering for: 5 4 3 2 and AM or PM or Both

Which days are you registering for: Mon____ Tues____ Wed____ Thurs____ Fri____

A $110.00 Non-refundable registration fee is required with this form at the time of registration. Please note that the June tuition is not refundable once the program has begun. A 30–day notice is needed in writing to drop from the program. A one-time $200 Annual Transportation Fee for those needing transportation (Sibling discount is $150 for the second child additional children free) For student riding the Puesta del Sol Bus to/from Samena the Fee is $100.

----------**For Office Use Only**----------

Registration: Deposit Paid: _____ $_____ Check #_____Received by_____

First Month Tuition Paid: _____$_____ Check # _____Received by_____

June Tuition Paid: _____$_____ Check #_____ Received by_____

Annual Transportation Fee: _____ $_____ Check #_____ Received by_____

2017-2018 Samena Before & After School Program Contract

Thank you for choosing Samena for your childcare needs. We look forward to having your child in our program this school year. Please read and sign this form and return this with your completed registration packet.

Payment Policy:

- **Tuition payments** are due by the first of the month.
- **Prior to the first day** of aftercare, we must receive first month's and June's tuition.
- **Monthly tuition** is calculated based on the total cost of the school year and then divided by 10 months. This allows all monthly payments to be the same regardless of the number of days in the month. There is no change in tuition due to family vacations, time off etc.
- **Cancellation Policy:** A written 30-day notice before the first of the month in which you wish the changes to take place is required to cancel/switch days or drop from the program. Our before and after school year program is designed to operate on the school year calendar with a commitment for September through June.
- **June Tuition:** June tuition is non-refundable once the program has begun.

Additional Fees:

- **Registration Fee:** $110 per family
- **Annual Transportation Fee:** $200 per child (Sibling discount $150 for 2nd child, 3rd child free)
- **Schedule Changes:** There is no charge to add days to your current program if space is available. There is a $50 change fee to decrease the number of days attending.
- **Non-School Days:** A separate registration process and fees apply for Bellevue School District non-school days. Registration may be handled at the front desk. The non-school days include winter break, mid-winter break and spring break. Care for these days is not included in your tuition.
- **Late Pick Ups:** Our program closes at 6:30PM. A $10 fee is charged for EVERY 10 minutes you are late past 6:30pm. The late fee is paid the day of the occurrence at the front desk. Please call if you will be late for any reason!

Additional Information:

- **State Licensing Mandatory Paperwork:** A completed registration packet must be on site prior to the child beginning care. This includes the registration form, medical form, consent for care, program waiver, completed immunization form, signed contract.
- **Van Policy:** The van will wait at the school for 10 minutes at the designated loading area. If the child does not arrive within 10 minutes, the van will return to Samena and the child's parents will be contacted. It is the responsibility of the parents or school to transport a child who misses the Samena van. ***Please notify Samena by 12pm, in advance, if your child will not be attending for the day.***
- **Medication:** If your child requires medication you will need to complete the medication information sheet enclosed authorizing Samena staff to administer medications to your child. All medication must be in its original container with written directions / dose and time for your child.
- **Communication:** For your child's safety, we ask that you provide in writing any changes to your emergency contacts including address and phone changes.

I/we also agree to the Terms of the Samena Club Before and After School Care as listed on this contract. I have read and understand the terms of this agreement. I have received a copy of the Samena Club Before and After School Care Rules and Regulations and guidelines. I agree that I and all persons participating in the Samena Club Before and After School Care are bound by and shall comply with the rules and regulations of the Club as they may be amended from time to time.

Name_____Date_____

2017-2018 Samena Before & After School

Medical Information Form

☐**Member** ☐**Program Member/Non-Member**

Please print and complete all details.

Child's Name: _____Date of Birth:____/____/____Gender:_____

Child's School: _____ Grade:_____

Parent/Guardian's Name: _____Day Phone:_____ Home_____

Name:_____ Day Phone:_____ Home:_____

Cell Phone: (____)_____ (if different from day phone)

Address: _____

City: _____ State: _____ Zip: _____

E-Mail Address:_____

Medical Information:

1. Physician's Name: _____ Phone :(_____)_____
2. Date of last physical/Dr. Appointment: _____
3. Dentist's Name: _____ Phone: (_____)_____
4. Date of last dental exam _____
5. Is your child currently taking any medications? □No □Yes
   If Yes, please describe:

_____

Dosage:_____

6. Does your child have any allergies? □No □Yes
7. Hospital Preference:_____
8. Does your child have swim experience? If so explain_____
9. Are there other special needs which the Samena Staff should be aware of?

_____

Emergency Contact Information

In case of an extreme emergency, the Samena Staff is directed to call 911 immediately, then the parent or guardian. If you cannot be reached, please list two people most likely to be home and able to assist your child.

Name: _____ Phone: (day) _____

Relation: _____ Phone: (evening) _____

Name: _____ Phone: (day) _____

Relation: _____ Phone: (evening) _____

Other authorized people allowed to pick up my child:

Names:

_____

_____

_____

Samena Swim & Recreation Club

2017-2018 Before & After School Program Waiver

I _____,(parent/guardian) of:

_____
(child's name)
give my permission for him/her to participate in the Samena Swim and Recreation Club's Children's Program activities and outings.
I hereby release the Samena Club and its officers and employees from any legal responsibility should a question of liability occur.

_____ _____
Signature of parent or legal guardian Date

Samena Swim and Recreation Club
Consent to Medical Care and Treatment of Minor Children

I,_____(parent/legal guardian)

hereby give permission that my child,

_____
(child's name)
may be given emergency treatment to include first aid and CPR by a qualified staff member at Samena Club. I further authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health in case I cannot be contacted. I waive my right of informed consent to such treatment. I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

_____ _____
Signature of parent or legal guardian Date

Additional comments:
____ I provide permission for the Samena Club to use any pictures of my child in future promotional purposes for The Samena Club only. (Photos will not be sold)

Certificate of Immunization Status (CIS)

DOH 348-013 January 2015

Office Use Only:	
Reviewed by:	Date:
Signed Cert. of Exemption on file? ❑ Yes ❑ No	

Please print. See back for instructions on how to fill out this form or get it printed from the Immunization Information System.

Child's Last Name: **First Name:** **Middle Initial:** **Birthdate** (mm/dd/yyyy)**:** **Sex:**

Symbols below: ◆ Required for School and Child Care/Preschool
● Required for Child Care/Preschool Only
■ Recommended, but not required

I certify that the information provided on this form is correct and verifiable.

Parent/Guardian Signature Required **Date**

I give permission to my child's school to share immunization information with the Immunization Information System to help the school maintain my child's school record.

Parent/Guardian Signature Required **Date**

Vaccine	Dose	Date		
		Month	Day	Year
◆ Hepatitis B (Hep B)				
	1			
	2			
	3			
or Hep B - 2 dose alternate schedule for teens				
	1			
	2			
■ Rotavirus (RV1, RV5)				
	1			
	2			
	3			
◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)				
	1			
	2			
	3			
	4			
	5			
◆ Tetanus, Diphtheria, Pertussis (Tdap)				
	1			
■ Tetanus, Diphtheria (Td)				
	1			
	2			
● *Haemophilus influenzae* type b (Hib)				
	1			
	2			
	3			
	4			
■ Influenza (flu, most recent)				

Vaccine	Dose	Date		
		Month	Day	Year
● Pneumococcal (PCV, PPSV)				
	1			
	2			
	3			
	4			
	5			
◆ Polio (IPV, OPV)				
	1			
	2			
	3			
	4			
◆ Measles, Mumps, Rubella (MMR)				
	1			
	2			
◆ Varicella (chickenpox)				
	1			
	2			
■ Hepatitis A (Hep A)				
	1			
	2			
■ Human Papillomavirus (HPV) – does not print from the IIS; write dates in by hand				
	1			
	2			
	3			
■ Meningococcal (MCV, MPSV)				
	1			
	2			

If the child named on this CIS had chickenpox disease (and not the vaccine), disease history must be verified.
Mark option 1, 2, OR 3 below (see # 5 on back)

1) ❑ Chickenpox disease verified by printout from the Immunization Information System (IIS)
Must be marked by printout (not by hand) to be valid.

2) ❑ Chickenpox disease verified by healthcare provider (HCP)
If you choose this box, mark 2A **OR** 2B below.
2A) ❑ Signed note from HCP attached **OR**
2B) ❑ HCP sign here and print name below:

Licensed healthcare provider signature (MD, DO, ND, PA, ARNP) **Date**

Printed Name:

3) ❑ Chickenpox disease verified by school staff from the Immunization Information System

If the child can show immunity by blood test (titer) and hasn't had the vaccine, ask your HCP to fill in this box.

Documentation of Disease Immunity

I certify that the child named on this CIS has laboratory evidence of immunity (titer) to the diseases marked.
Signed lab report(s) MUST also be attached.

❑ Diphtheria
❑ Hepatitis A
❑ Hepatitis B
❑ Hib
❑ Measles
❑ Mumps
❑ Polio
❑ Rubella
❑ Tetanus
❑ Varicella
❑ Other: _____
_____

Licensed healthcare provider signature (MD, DO, ND, PA, ARNP) **Date**

Printed Name:

Instructions for completing the Certificate of Immunization Status (CIS): printing it from the Immunization Information System (IIS) or filling it in by hand.

#1 To print with information filled in: First, ask if your healthcare provider's office puts vaccination history into the WA Immunization Information System (Washington's statewide database). If they do, ask them to print the CIS from the IIS and your child's information will fill in automatically. **Be sure** to review all the information, **sign and date the CIS**, and return it to school or child care. If your provider's office does not use the IIS, ask for a copy of your child's vaccine record so you can fill it in by hand using steps #2-7 (below):

EXAMPLE

#2 To fill in by hand: Print your child's name, birthdate, sex, and your own name in the top box.

#3 Write each vaccine your child received under the correct disease. Write the vaccine type under the "Vaccine" column and the date each dose was received in the "Month," "Day," and "Year" columns (as mm/dd/yyyy). For example, if DTaP was received Jan 12, March 20, June 1, '11, fill in as shown here ▶

Vaccine	Dose	Date		
		Month	Day	Year
◆ **Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)**				
DTaP	**1**	01	12	2011
DTaP	**2**	03	20	2011
DTaP	**3**	06	01	2011

#4 If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guide below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as **DTaP**, Hepatitis B as **Hep B**, and Polio as **IPV**.

#5 If your child had chickenpox (varicella) disease and not the vaccine, **use only one** of these three options to record this on the CIS:

1) ❑ If your child's CIS is printed directly from the IIS (by your healthcare provider or school), and disease verification is found, box 1 is automatically marked. To be valid, this box must be marked by the IIS printout (not by hand).

2) ❑ If your healthcare provider can verify that your child had chickenpox, mark box 2. Then mark either 2A to attach a signed note from your provider, or 2B if your provider signs and dates in the space provided. Be sure your provider's full name is also printed.

3) ❑ If school staff access the IIS and see verification that your child had chickenpox, they will mark box 3.

#6 Documentation of Disease Immunity: If your child can show immunity by blood test (titer) and has not had the vaccine, have your healthcare provider fill in this box. Ask your provider to mark the disease(s), sign, date, print his or her name in the space provided, and **attach signed lab reports**.

#7 Be sure to **sign and date the CIS**, and return to the school or child care.

Reference Guide

Vaccine Trade Names in alphabetical order (For updated lists, visit https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf)

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB	Hib	FluLaval	Flu	Ipol	IPV	PedvaxHIB	Hib	Twinrix (Twnrx)	Hep A + Hep B
Adacel	Tdap	FluMist	Flu	Infanrix	DTaP	Pentacel (Pntcl)	DTaP + Hib + IPV	Vaqta	Hep A
Afluria	Flu	Fluvirin	Flu	Kinrix (Knrx)	DTaP + IPV	Pneumovax	PPSV or PPV23	Varivax	Varicella
Boostrix	Tdap	Fluzone	Flu	Menactra	MCV or MCV4	Prevnar	PCV or PCV7 or PCV13		
Cervarix	HPV2	Gardasil	HPV4	MenHibrix (Mnhbrx)	Meningococcal C/Y-HIB-PRP	ProQuad (PrQd)	MMR + Varicella		
Daptacel	DTaP	Havrix	Hep A	Menomune	MPSV or MPSV4	Recombivax HB	Hep B		
Engerix-B	Hep B	Hiberix	Hib	Menveo	Meningococcal	Rotarix	Rotavirus (RV1)		
Fluarix	Flu	HibTITER	Hib	Pediarix (Pdrx)	DTaP + Hep B + IPV	RotaTeq	Rotavirus (RV5)		

Vaccine Abbreviations in alphabetical order (For updated lists, visit https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf)

Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A (HAV) Hep B (HBV)	Hepatitis A Hepatitis B	MPSV or MPSV4	Meningococcal Polysaccharide Vaccine	Rota (RV1 or RV5)	Rotavirus
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hib	*Haemophilus influenzae* type b	MMR / MMRV	Measles, Mumps, Rubella / with Varicella	Td	Tetanus, Diphtheria
DTP	Diphtheria, Tetanus, Pertussis	HPV	Human Papillomavirus	OPV	Oral Poliovirus Vccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
Flu (IIV or LAIV)	Influenza	IPV	Inactivated Poliovirus Vaccine	PCV or PCV7 or PCV13	Pneumococcal Conjugate Vaccine	TIG	Tetanus immune globulin
HBIG	Hepatitis B Immune Globulin	MCV or MCV4	Meningococcal Conjugate Vaccine	PPSV or PPV23	Pneumococcal Polysaccharide Vaccine	VAR or VZV	Varicella

If you have a disability and need this document in another format, please call 1-800-525-0127 (TDD/TTY call 711).

DOH 348-013 January 2015

Samena Swim &Recreation Club

Medication Dispensing Form

Child's Name _____

Reason for Medication:_____

Name of Medication: _____

How much to give: _____

When to give: _____

How to give:

____Oral (by mouth)
____Topical (to skin)
____Other (please explain)_____

When the treatment should be stopped: _____

Requires Refrigeration: _____Yes _____No

Possible side effects:_____

Special instructions/suggestions (e.g. take with food, with water etc.):
_____

Parent signature_____ Date_____

*Note: You need a physician's signature for non-prescription medications if:

1. There are no instructions on the container for use of the medication for child's age or
2. The medication is **not** listed below:

- Antihistamines (Benadryl, Sudafed)
- Non-aspirin pain relievers and fever reducers (Tylenol, Datril, Liquiprin)
- Cough medicines (Robitussin, Triaminic)
- Decongestants (Dimetapp, Pediacare, Robitussin)
- Anti-itching creams (Caladryl, Delacort)
- Sunscreens (recommended to be applied by a parent/guardian)

Samena Swim & Recreation Club

Before & After School Care Program
Withdrawal Policy

Thank you for choosing Samena to provide Before or After School care for your child. We understand that changes occur in everyone's lives and schedules and we want to be as accommodating as possible. We require a 30 day notice before withdrawing from our program. We have attached the tear-off sheet at the bottom of the page for your convenience. Please fill out the necessary information completely and return it to the Program Director. All tuition must be current and if there are any outstanding payments they must be paid in full at the time of withdrawal.

——————————Please Return——————————

Before & After School Program Withdrawal Request Form

Date: _____

Child's Name: _____

Parent's Name: _____

Phone#: _____

Current day's attending: _____

Name of school child attends: _____

Last day child will be attending: _____

Reason for leaving program _____

_____

Signature of Parent:_____

AUTHORIZATION AGREEMENT FOR AUTOMATIC PAYMENTS FROM CREDIT CARD

Company: **SAMENA CLUB**

I (we) hereby authorize the above named company, hereinafter called COMPANY, to initiate debit entries to my credit card account identified below.

Credit Card type: (Please circle one) Visa Mastercard Discover

- Account No. _____
- Expiration Date: _____
- Name on Credit Card: _____
- Street Address credit card statement is sent to: _____
- Zip Code: _____

This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it. I (or either of us) have the right to stop payment of a debit entry by notification to DEPOSITORY at least three days prior to my (our) next payment. In case of an erroneous debit, provided I (we) supply notice to DEPOSITORY within 60 days of receiving my (our) account statement, the DEPOSITORY must investigate and resolve the error within 45 days, but if it has not done so within 10 days, my (our) account will be re-credited for the amount in question while it finishes the investigation.

Membership Number _____

Primary Member Name (Please Print) _____

Primary Member Signature _____Date Signed _____

Spouse Name (if applicable) (Please Print or Type) _____

Spouse Signature _____Date Signed _____

15231 Lake Hills Blvd. Bellevue WA 98007
(425) 746-1160 Attn: Sharon McClain (Ext. 114) Fax: (425) 746-4485