SAMENA

• SWIM & RECREATION CLUB •

SAMENA SCHOOL & BEFORE & AFTER CARE

Registration Packet 2020/2021

All forms are due in completion at time of registration.

Tuition Information

Registration Form

B&A Program Contract
(Parent copy included)

Medical Information

Program Waiver & Parent Consent Form

Medication Dispensing Form

Immunization Record or Certificate of Exemption

Program Withdrawal Form
(Parent copy to keep)

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: Jason Menia, ext.128;
jasonm@samena.com

Samena School

4 Week Session

8:30am-3:30pm

5 Days	Monthly Tuition
Member	$1,000
Non Member	$1,200
4 Days	**Monthly Tuition**
Member	$875
Non Member	$1,050
3 Days	**Monthly Tuition**
Member	$725
Non Member	$900

Samena School Extended Care

4 Week Session

AM-2 Hours 6:30am-8:30am

PM-3 Hours: 3:30pm-6:30pm

AM & PM-5 Hours

Extended Pricing for those enrolled in Samena School

5 Days	Monthly Tuition
Member	
AM Care	**$300**
PM Care	**$460**
AM & PM Care	**$760**
Non Member	
AM Care	**$340**
PM Care	**$500**
AM & PM Care	**$800**

4 Days	Monthly Tuition
Member	
AM Care	**$255**
PM Care	**$385**
AM & PM Care	**$625**
Non Member	
AM Care	**$290**
PM Care	**$415**
AM & PM Care	**$655**

3 Days	Monthly Tuition
Member	
AM Care	**$205**
PM Care	**$300**
AM & PM Care	**$480**
Non Member	
AM Care	**$230**
PM Care	**$325**
AM & PM Care	**$505**

2020-2021 Samena Before & After School Tuition

5 Day Monthly	Member	Non Member
Before Care	$351	$451
2nd Child	$281	$352
3rd Child	$176	$226
After Care	$593	$704
2nd Child	$445	$549
3rd Child	$297	$352
B & A Care	$693	$814
2nd Child	$554	$635
3rd Child	$347	$407

4 Day Monthly	Member	Non Member
Before Care	$316	$406
2nd Child	$253	$317
3rd Child	$158	$203
After Care	$534	$634
2nd Child	$400	$494
3rd Child	$267	$317
B & A Care	$641	$733
2nd Child	$513	$586
3rd Child	$321	$366

3 Day Monthly	Member	Non Member
Before Care	$269	$345
2nd Child	$211	$264
3rd Child	$134	$173
After Care	$454	$558
2nd Child	$354	$435
3rd Child	$227	$279
B & A Care	$545	$659
2nd Child	$425	$527
3rd Child	$272	$330

2 Day Monthly	Member	Non Member
Before Care	$228	$293
2nd Child	$171	$220
3rd Child	$114	$147
After Care	$386	$491
2nd Child	$316	$383
3rd Child	$193	$245
B & A Care	$463	$580
2nd Child	$380	$453
3rd Child	$232	$290

SAMENA

•SWIM & RECREATION CLUB•

2020-2021 Samena School/ B&A Program Contract

PARENT COPY

Original must be signed on Reverse of Registration Form

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:

- **First Session Tuition** is due at the time of registration.
- **Deposit for consecutive session**: Spots may be reserved for consecutive session with a $150 nonrefundable deposit.
- **Monthly tuition payments**: Due 2 weeks prior to the session. If payment is not made, spot will be released to participants on the waitlist. Families can select to have automatic withdrawal for tuition payments.
- **School Resumes**: If school resumes during a session, Samena will issue a credit or refund for the prorated tuition.
- **Cancellation Policy:** A written 2 week 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 session. If 2 week notice is provided, tuition payments minus the $150 deposit will be credited or refunded. No refunds or credits once a session begins.

Additional Fees:

- **One-time Registration Fee:** $115 non-refundable fee per family is due at time of registration.
- **Schedule Changes:** There is no charge to add days to your current program if space is available. There is a $50 per child change fee to decrease the number of days attending.
- **Late Pick Ups:** A $10 fee is charged for every 10 minutes you are late past your designated end of day. 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:

- **Mandatory State Licensing Paperwork:** A completed registration packet must be on site prior to the child beginning care. This includes the registration form, medical form with signed waiver, completed immunization form, and signed contract.
- **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.

SAMENA
• SWIM & RECREATION CLUB •

2020-2021
Samena School / Before & After Care
Registration Form

Contact Information	
Child's Name: (First, Middle, Last)	
Parent / Legal Guardian Name:	
Email:	Phone Number(s):
Address:	
Child's Birthdate:	Age at Start of School:
Samena School Registration Information	
Days Needed: ☐ 5 ☐ 4 ☐ 3	
Days: ☐ Mon ☐ Tues ☐ Weds ☐ Thurs ☐ Fri	
Extended Care Needed: ☐ AM ☐ PM ☐ Both	
Samena Before & Aftercare Registration Information	
Days Needed: ☐ 5 ☐ 4 ☐ 3 ☐ 2	
Days: ☐ Mon ☐ Tues ☐ Weds ☐ Thurs ☐ Fri	
Care Needed: ☐ AM ☐ PM ☐ Both	

Registration Fee- *$115 non-refundable required with this form at the time of registration*

Office Use Only

Registration Fee:

Amount Paid: _____ Date: _____ Staff: _____

Transportation Fee(s):

Amount Paid: _____ Date: _____ Staff: _____

SAMENA

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2020-2021 Samena School / B&A Program Contract

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Printed Name_____ Signature_____ Date_____

Samena School / B&A Medical Form

Last Name:	First Name:	Middle:
Birthdate (MM/DD/YYYY):		Nickname?
Street Address:	City:	Zip Code:
Child's Parent/Guardian Name(s):		
Cell Phone:	Home Phone:	Additional Phone:
(Alternate) Street Address:	City:	Zip Code:
Address of where we can reach you while child is in care:		

Authorized Pick Up		
(Fill in below line) Name / Relationship:	Address:	Telephone Numbers:
(Fill in below line) Name / Relationship:	Address:	Telephone Numbers:
(Fill in below line) Name / Relationship:	Address:	Telephone Numbers:
(Fill in below line) Name / Relationship:	Address:	Telephone Numbers:

Emergency Contact	
In case of an emergency, I give permission for any of the following individuals to be contacted, and my child may be released to any of them: Parent Signature: _____	
Name / Relationship:	Phone Number:
Name / Relationship:	Phone Number:
Who does not have permission to pick up your child? If applicable: **(A copy of supporting court document must be on file)**	
Name:	
Reason:	
If more, please attach separate sheet	

Child's Health Information

Child's Health Care Provider: Providers Telephone #:

Date of Child's Last Physical Exam:

Street address: City: Zip Code:

Special health problems? Yes or no? If yes, please specify:

Allergies, including drug reaction Yes or No? If yes, specify:

Child's Dental Information

Child's Dentist Name: Dentist Telephone #:

Date of Child's Last Dental Exam:

Street Address: City: Zip Code:

Child's Medical Insurance

Insurance Company: Member/Policy Number:

Policy Holder Name: Employer Name:

Consent to Medical Care, Treatment of Minor Children, and Program Waivers

I _____ (Parent / Legal Guardian) herby give permission that my child, _____ 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 of such treatment. I give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.
I give permission for him/her to participate in the Samena Club's Children's Program activities and outings.
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) unless denied in writing and attached to this form.

Signature of parent or legal guardian: _____ Date: _____

Printed name of parent or legal guardian: _____

Certificate of Immunization Status (CIS)

For Kindergarten-12th Grade / Child Care Entry

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 Washington Immunization Information System.

Child's Last Name:	**First Name:**	**Middle Initial:**	**Birthdate** (MM/DD/YY)**:**	**Sex:**

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**

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

Parent/Guardian Signature Required **Date**

♦ Required for School and Child Care/Preschool
● Required Only for Child Care/Preschool

	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY
Required Vaccines for School or Child Care Entry						
♦ **DTaP / DT** (Diphtheria, Tetanus, Pertussis)						
♦ **Tdap** (Tetanus, Diphtheria, Pertussis)						
♦ **Td** (Tetanus, Diphtheria)						
♦ **Hepatitis B** ❑ 2-dose schedule used between ages 11-15						
● **Hib** (*Haemophilus influenzae* type b)						
♦ **IPV / OPV** (Polio)						
♦ **MMR** (Measles, Mumps, Rubella)						
● **PCV / PPSV** (Pneumococcal)						
♦ **Varicella** (Chickenpox) ❑ History of disease verified by IIS						
Recommended Vaccines (Not Required for School or Child Care Entry)						
Flu (Influenza)						
Hepatitis A						
HPV (Human Papillomavirus)						
MCV / MPSV (Meningococcal)						
MenB (Meningococcal)						
Rotavirus						

Documentation of Disease Immunity

Healthcare provider use only

If the child named in this CIS has a history of Varicella (Chickenpox) or can show immunity by blood test (titer) it MUST be verified by a healthcare provider

I certify that the child named on this CIS has:

❑ a verified history of Varicella (Chickenpox).

❑ laboratory evidence of immunity (titer) to disease(s) marked below. **Lab report(s) for titers MUST also be attached.**

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

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.

To print with immunization information filled in: Ask if your healthcare provider's office enters immunizations 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 immunization information will fill in automatically. You can also print a CIS at home by signing up and logging into MyIR at https://wa.myir.net. **If your provider doesn't use the IIS, email or call the Department of Health to get a copy of your child's CIS: waiisrecords@doh.wa.gov or 1-866-397-0337.**

To fill out the form by hand:

#1 Print your child's name, birthdate, sex, and sign your name where indicated on page one.

#2 Vaccine information: Write the date of each vaccine dose received in the date columns (as MM/DD/YY). If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guides 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**.

#3 History of Varicella Disease: If your child had chickenpox (varicella) disease and not the vaccine, **a health care provider must verify chickenpox disease to meet school requirements**.

- ❑ If your healthcare provider can verify that your child had chickenpox, ask your provider to check the box in the Documentation of Disease Immunity section and sign the form.
- ❑ If school staff access the IIS and see verification that your child had chickenpox, they will check the box under Varicella in the vaccines section.

#4 Documentation of Disease Immunity: If your child can show positive immunity by blood test (titer) and has not had the vaccine, have your healthcare provider check the boxes for the appropriate disease in the Documentation of Disease Immunity box, and sign and date the form. **You must provide lab reports with this CIS**.

Reference guide for vaccine abbreviations in alphabetical order For updated list, 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	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A	Hepatitis A	MCV / MCV4	Meningococcal Conjugate Vaccine	OPV	Oral Poliovirus Vaccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hep B	Hepatitis B	MenB	Meningococcal B	PCV / PCV7 / PCV13	Pneumococcal Conjugate Vaccine	VAR / VZV	Varicella
DTP	Diphtheria, Tetanus, Pertussis	Hib	*Haemophilus influenzae* type b	MPSV / MPSV4	Meningococcal Polysaccharide Vaccine	PPSV / PPV23	Pneumococcal Polysaccharide Vaccine		
Flu (IIV)	Influenza	HPV (2vHPV / 4vHPV / 9vHPV)	Human Papillomavirus	MMR	Measles, Mumps, Rubella	Rota (RV1 / RV5)	Rotavirus		
HBIG	Hepatitis B Immune Globulin	IPV	Inactivated Poliovirus Vaccine	MMRV	Measles, Mumps, Rubella with Varicella	Td	Tetanus, Diphtheria		

Reference guide for vaccine trade names in alphabetical order For updated list, 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	Fluarix®	Flu	Havrix®	Hep A	Menveo®	Meningococcal	Rotarix®	Rotavirus (RV1)
Adacel®	Tdap	Flucelvax®	Flu	Hiberix®	Hib	Pediarix®	DTaP + Hep B + IPV	RotaTeq®	Rotavirus (RV5)
Afluria®	Flu	FluLaval®	Flu	HibTITER®	Hib	PedvaxHIB®	Hib	Tenivac®	Td
Bexsero®	MenB	FluMist®	Flu	Ipol®	IPV	Pentacel®	DTaP + Hib + IPV	Trumenba®	MenB
Boostrix®	Tdap	Fluvirin®	Flu	Infanrix®	DTaP	Pneumovax®	PPSV	Twinrix®	Hep A + Hep B
Cervarix®	2vHPV	Fluzone®	Flu	Kinrix®	DTaP + IPV	Prevnar®	PCV	Vaqta®	Hep A
Daptacel®	DTaP	Gardasil®	4vHPV	Menactra®	MCV or MCV4	ProQuad®	MMR + Varicella	Varivax®	Varicella
Engerix-B®	Hep B	Gardasil® 9	9vHPV	Menomune®	MPSV4	Recombivax HB®	Hep B		

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 December 2016

Washington State Department of Health

DOH 348-106 Jan 2015

Certificate of Exemption

SIDE A:
For Religious, Personal, Philosophical, and Medical Exemptions[1]

FOR OFFICE USE ONLY CHILD'S LAST NAME _____ FIRST NAME _____ M.I. _____

PART 1: PARENT OR GUARDIAN INSTRUCTIONS

In order for this form to be valid for religious, personal, philosophical, or medical reasons, please:

Step 1: Fill in your child's information in Boxes 1-4
Step 2: Read the Parent/Guardian Declaration
Step 3: Provide your initials where indicated
Step 4: Print your name, sign, and date in Boxes 5-6
Step 5: Have a provider complete Part 2 of this form

1. Child's Last Name

2. Child's First Name and Middle Initial

3. Birthdate (mm/dd/yyyy) _____/_____/_____

4. Gender
☐ Male
☐ Female

I am the parent or legal guardian of the above named child. One or more required vaccines are in conflict with my personal, philosophical, or religious beliefs.

Parent/Guardian Declaration

I understand that:

- *My child may not be allowed to attend school or child care during an outbreak of the disease that my child has not been fully vaccinated against.* _____ ***(initial)***
- *Exempting my child from any or all required vaccine(s) may result in serious illness, disability, or death to my child or others. I understand the risks and possible outcomes of my decision to exempt my child.* _____ ***(initial)***
- *The information provided on this form is complete and correct.* _____ ***(initial)***

5. Print Parent/Guardian Name

6. Parent/Guardian Signature and Date _____/_____/_____

PART 2: HEALTHCARE PROVIDER INSTRUCTIONS

In order for this form to be valid, please:

Step 1: Mark which disease(s) and what type of exemption is requested. If medical write a **T** for Temporary or **P** for Permanent.
Step 2: Discuss the benefits and risks of immunizations with the parent or guardian
Step 3: Read the Provider Declaration
Step 4: Print your name, credentials, sign, and date in Boxes 7-8

Vaccine	Personal/ Philosophical	Religious	Medical (T/P)**	Expiration Date for Temporary Medical
Diphtheria				
Hepatitis B				
Hib				
Measles				
Mumps				
Pertussis				
Pneumococcal				
Polio				
Rubella				
Tetanus				
Varicella				
All				

***A provider may grant a medical exemption only if there is a medical contraindication to a vaccine.*

Provider Declaration

I declare that:

- *I have discussed the benefits and risks of immunizations with the parent/legal guardian as a condition for exempting their child.*
- *I am a qualified MD, ND, DO, ARNP or PA licensed under Title 18 RCW.*
- *The information provided on this form is complete and correct.*

7. Print Provider Name and Credential **(MD, ND, DO, ARNP, PA)**

8. Provider Signature and Date _____/_____/_____

[1]RCW 28A.210.080-090 "Before or on the first day of every child's attendance at any public and private school or licensed child care center in Washington State, the parent or guardian must present proof of either: (1) full immunization, (2) the initiation of and compliance with a schedule of immunization, as required by rules of the State Board of Health, or (3) a certificate of exemption signed by a parent or guardian and is either A) signed by a licensed healthcare provider or B) demonstrates membership in a church or religious body that precludes healthcare practitioners from providing medical treatment to children."

Washington State Department of Health

Certificate of Exemption

SIDE B:
For Religious Membership Exemption ONLY

FOR OFFICE USE ONLY CHILD'S LAST NAME FIRST NAME M.I.

NOTICE: Complete this side if you belong to a church or religion that objects to the use of medical treatment.[1]

If you have a religious objection to vaccinations, but the beliefs or teachings of your church or religion allow for your child to be treated by medical professionals such as doctors and nurses, then you must use Side A of this Certificate of Exemption.

PARENT OR GUARDIAN INSTRUCTIONS

In order for this form to be legally valid for religious membership reasons, please:

Step 1: Fill in your child's information in Boxes 1-4
Step 2: Read the Parent/Guardian Declaration and provide your initials where indicated
Step 3: Provide the name of the church or religion of which you are a member, and print your name, sign, and date in Boxes 5-7

1. Child's Last Name

2. Child's First Name and Middle Initial

3. Birthdate (mm/dd/yyyy)
_____/_____/_____

4. Gender
☐ M ☐ F

I am the parent or legal guardian of the above named child and I am exempting my child from all required vaccinations.

Parent/Guardian Declaration

I understand that:

- *My child may not be allowed to attend school or child care during an outbreak of the disease that my child has not been fully vaccinated against.* _____ ***(initial)***
- *Exempting my child from all required vaccines may result in serious illness, disability, or death to my child or others. I understand the risks and possible outcomes of my decision to exempt my child.* _____ ***(initial)***
- *The information provided on this form is complete and correct.* _____ ***(initial)***

I affirm that I am a member of a church or religion whose teachings preclude healthcare practitioners from providing any medical treatment to my child.

5. Name of Church or Religion of Which You Are a Member

6. Print Parent/Guardian Name

7. Parent/Guardian Signature and Date
_____/_____/_____

[1]RCW 28A.210.090 "The parent of legal guardian demonstrates membership in a religious body or a church in which the religious beliefs or teachings of the church preclude a health care practitioner from providing medical treatment to the child."

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)

AUTHORIZATION AGREEMENT FOR
CREDIT or DEBIT CARD (EFT) AUTOMATIC PAYMENTS

For Automatic Payment from Bank Account (ACH), please fill out reverse side instead

Company: **SAMENA CLUB**

I (we) hereby authorize Samena Club or its authorized credit/debit card transaction agent(s) to bill my credit/debit card account indicated below for monthly payment.

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

- Last 4 digits of credit card # ___ ___ ___ ___
- Expiration Date: ___ ___ /___ ___
- CVV# (3 or 4 digits): ___ ___ ___ ___
- Name on Card: _____
- Street Address credit card statement is sent to: _____
- Zip Code: _____

This authority is to remain in full force and effect until Samena Club has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Samena Club and the DEPOSITORY a reasonable opportunity to act on it. If I change the account number or financial institution specified, I will provide written authorization for the change to Samena Club.

Membership Number: _____

Primary Member Name: (Please Print) _____

Primary Member Signature: _____Date Signed:_____

Spouse: (if applicable)

Spouse Name: (Please Print or Type) _____

Spouse Signature: _____Date Signed: _____

15231 Lake Hills Blvd. Bellevue WA 98007
Attn: Rachel Perez (425) 746-1160 ext 124 rachelp@samena.com