Unique After Care
2019-2020

ITEMS TO BRING

- Immunization Record **(Form 3231)**
- IEP or 504 Plan
- Completed Registration Form **(Print Please)**
- Payment (Money Order, Check, or Cash)

Per week: 1:5 - $100.00
1:1 - $150.00 **(Any restroom assistance)**

Unique After Care 2019-2020
Participation Application
PLEASE PRINT

Child Name (Please Print)_____Age_____
Last Name First Name

Date of Birth_____Male_____Female_____

Address_____City_____State_____Zip_____

School Attends:_____

Parent/Guardian Information

Mother/Guardian Name:_____

Address:_____

City _____ County_____State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email Adress_____

Mother's Place of employment:_____ Work Phone_____

Employer's Street Address _____ City_____ State___ Zip_____

Father/Guardian Name:_____

Address:_____

City _____ County_____State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email Adress_____

Father's Place of employment:_____ Work Phone_____

Employer's Street Address _____ City_____ State___ Zip_____

Child's Living Arrangements: (Check one)

( ) Both Parents ( ) Mother ( ) Father ( ) Other

Child's Legal Guardian(s): (Check one)

( ) Both Parents ( ) Mother ( ) Father ( ) Other

If there are any court document stating one parent is not authorized to pick up child, U.I needs a copy of the court order to comply.

Parent Authorized Persons To Pick Up Child

(All Persons picking up child MUST show picture identification in order for child to be released. This is to ensure the safety of your child.)

1. Name_____ Relationship to child_____

Complete Address_____

Home Number_____ Cell Number_____

Relationship to Parent(s) or Guardian_____

2. Name_____ Relationship to child_____

Complete Address_____

Home Number_____ Cell Number_____

Relationship to Parent(s) or Guardian_____

3. Name_____ Relationship to child_____

Complete Address_____

Home Number_____ Cell Number_____

Relationship to Parent(s) or Guardian_____

By signing below, I am allowing my child to be released to the person(s) above.

Sign_____ Date_____

Emergency Contacts

Persons to contact in case of emergency when parent or guardian cannot be reached:

Name_____ Telephone Number_____

Name_____ Telephone Number_____

Name_____ Telephone Number_____

The following people are not authorized to pick-up my child **(If this person is the child's parent you must include a court order)**

Name_____ Relationship_____

Name_____ Relationship_____

Hospital to take child in case:_____

Child's doctor or clinic name:_____

Doctor/clinic phone number:_____

Emergency Medical Authorization

Should (child's name)_____Date of birth_____
Suffer an injury or illness while in the care of **Unique After Care** and the facility is unable to contact me (us) immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. I (We) shall assume responsibility for payment for services.

Parent/Guardian_____
Print name

_____ _____
Sign name Date

Emergency Medical/Personal Information

Name of Primary Disability_____

Classification of Disability: **(Check one)** High Function_____Low Function _____

Please describe your child disability _____

_____

_____

Please describe any triggers that set your child off

_____

_____

_____

When upset, what behavior does your child display_____

_____

_____

What calms your child down_____

_____

_____

What is your child allergic to_____

_____

_____

Parent or Guardian's
Notice of No Liability Insurance and Acknowledge

I understand that I am being informed in writing by signing this acknowledgement that this facility does not carry liability insurance sufficient to protect my child in the event of an injury, ect.

_____ _____
Parent or Guardian's Signatures Date

_____ _____
Parent or Guardian's (Print Name) Date

_____ _____
Director Signature Date