

# After-School Plus (A+) Program Registration Form

For official use only.  
\_\_\_\_ Checked eligibility status.

Signature of Site Coordinator \_\_\_\_\_ Date \_\_\_\_\_

## STUDENT INFORMATION

1st Child's Name \_\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_

Other educational/health information about student: **A+** **Before Care**

2nd Child's Name \_\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_

Other educational/health information about student: **A+** **Before Care**

3rd Child's Name \_\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_

Other educational/health information about student: **A+** **Before Care**

School \_\_\_\_\_ Phone \_\_\_\_\_ Circle Days Attending M Tu W Th F

Language spoken at home: \_\_\_\_\_ Ethnicity (optional) \_\_\_\_\_

Child Resides with: \_\_\_\_\_

## FAMILY INFORMATION

Mother/Legal Guardian's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Mother's Mailing Address \_\_\_\_\_  
Street City Zip Code

Mother's E-Mail Address \_\_\_\_\_

Mother's Employer/School \_\_\_\_\_ Work/Cellular Phone \_\_\_\_\_

Mother's Employer/School Address \_\_\_\_\_  
Street City Zip Code

Mother is authorized to pick-up: Yes \_\_\_\_\_ No \_\_\_\_\_

Father/Legal Guardian's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Father's Mailing Address \_\_\_\_\_  
Street City Zip Code

Father's E-Mail Address \_\_\_\_\_

Father's Employer/School \_\_\_\_\_ Work/Cellular Phone \_\_\_\_\_

Father's Employer/School Address \_\_\_\_\_  
Street City Zip Code

Father is authorized to pick-up: Yes \_\_\_\_\_ No \_\_\_\_\_

**List below adult individual(s) authorized to pick-up your child from the facility and their phone numbers.  
(The child will not be released to any individual not listed below.)**

Name	Relationship to Child	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Any changes in departure authorization must be received in writing from the parent/legal guardian.**

## After-School Plus (A+) Program Registration Form

**The After-School Plus (A+) Program**, the first program of its kind in the nation, provides statewide after-school services for public elementary students at affordable rates. The program addresses the “latch-key” child problem by providing a high quality after-school program to children of working parents/legal guardians or children whose parent/legal guardian is engaged in job training or attending school during the hours of A+ operations. If your child qualifies and you want to enroll him/her, please complete both sides of this registration form and return it to your child’s school.

**Fee: Due Monthly**

The monthly fee covers regular program activities. **The fee will be adjusted for those who qualify if acceptable supporting documentation about their income or DHS 728 Form is submitted.**

**Hours: After school - 5:30 p.m.**

The program hours are from after school to 5:30 p.m. on regular school days. The program will not operate during school vacations, state holidays, weekends, Teacher Institute Day, Teachers' work day and school half days.

**Supervision: Staff to Student Ratio of 1:20**

At each school, the staff will consist of a Site Coordinator and a group leader team supported by aides to maintain a staff to student ratio of 1:20. Staff recruitment may limit the number of students that a school can serve.

**Activities:** A variety of scheduled activities

Children usually begin the afternoon with free play time and a snack period (children bring their own snacks from home). This period is followed by other activities including homework time, enrichment and physical fitness. Site Coordinators will have the flexibility to adapt scheduled activities to meet the conditions at your child's school.

**Eligibility: K-6 public elementary school latchkey children**

Your child is considered latchkey if he/she is living with you and **during the hours of A+ operations** you are employed, attending school, engaged in a job training program, or working as an employee of the A+ program. A parent/legal guardian who is “self-employed” must verify their status by: a) Submitting a copy of their general excise tax license; and b) submitting a copy of one of the following: 1) income tax return for the past year including Schedule C; or 2) printed business checking account.

**Starting Date:** Child's first full day of school

Starting date for your child is usually the first full day of school. However, the starting date of the A+ Program at your child's elementary school may depend on the after-school enrollment of at least 20 children and the ability to recruit necessary staff.

Parent/Legal Guardian's Name (please type or print) _____	Parent/Legal Guardian's Name (please type or print) _____
Marital status (circle one): Single    Married    Divorced Separated    Widowed	Marital status (circle one): Single    Married    Divorced Separated    Widowed
Please check as appropriate: _____ working _____ job training    _____ attending school Work/school schedule (Please circle am and/or pm): Mon. _____ am/pm to _____ am/pm Tues. _____ am/pm to _____ am/pm Wed. _____ am/pm to _____ am/pm Thurs. _____ am/pm to _____ am/pm Fri. _____ am/pm to _____ am/pm <input type="checkbox"/> Check this box if you work rotating shifts or your work hours vary. Submit a sample schedule to Site Coordinator.	Please check as appropriate: _____ working _____ job training    _____ attending school Work/school schedule (Please circle am and/or pm): Mon. _____ am/pm to _____ am/pm Tues. _____ am/pm to _____ am/pm Wed. _____ am/pm to _____ am/pm Thurs. _____ am/pm to _____ am/pm Fri. _____ am/pm to _____ am/pm <input type="checkbox"/> Check this box if you work rotating shifts or your work hours vary. Submit a sample schedule to Site Coordinator.

\_\_\_\_\_ I would like to apply for subsidized monthly tuition. I give my permission to the Hawaii State Department of Education (HIDOE) and its contracted private providers to use information in HIDOE files or files from other state agencies to verify my child's eligibility for subsidized monthly A+ fees.

\_\_\_\_\_ I have attached the **required** supporting documentation. (Refer to **List of Acceptable Income Documentation for the After-School Plus (A+) Program** on the last page of the A+ Parent Handbook or check with your school's A+ Site Coordinator.)

I certify that I am eligible for the A+ Program because I am working, job training, and/or attending school during the hours of A+ operations. I further certify that the information I have provided on both sides of this application form is correct and I hereby authorize the HIDOE and its contracted private providers to contact the appropriate parties to verify this information. **I understand that changes on this registration form must be given to the A+ Site Coordinator in writing by the parent/legal guardian. Registration in the A+ Program is pending completion of this application and approval of the Site Coordinator.**

Parent/Legal Guardian _____ Date _____	Parent/Legal Guardian _____ Date _____
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## AFTER-SCHOOL PLUS (A+) PROGRAM REGISTRATION AGREEMENT

1<sup>st</sup> Child's Name \_\_\_\_\_ School \_\_\_\_\_

2<sup>nd</sup> Child's Name \_\_\_\_\_

3<sup>rd</sup> Child's Name \_\_\_\_\_

Parent/Legal Guardian \_\_\_\_\_

### PARENT/LEGAL GUARDIAN'S RESPONSIBILITIES AND BILLING PROCEDURES

**Parent/Legal Guardian's Responsibilities/Agreements:** Please initial each of the following to indicate that you have read, understand, and agree with each item.

I understand and agree that:

- \_\_\_\_\_ 1. My child(ren) is not allowed to come and go freely from the A+ Program site.
- \_\_\_\_\_ 2. My child(ren) must sign-in each day and I (or authorized adult) must sign him/her out each day.
- \_\_\_\_\_ 3. My child(ren) will be released only to adult(s) listed on the registration form.
- \_\_\_\_\_ 4. I must maintain communication with the Site Coordinator/Group Leader about my child(ren) and keep him/her informed of pertinent changes.
- \_\_\_\_\_ 5. I must notify the Site Coordinator/Group Leader of daily departure changes.
- \_\_\_\_\_ 6. I must contact the A+ Program when my child(ren) will be absent on any of his/her scheduled days of attendance, regardless of whether he/she was absent from school. I realize this is for my child(ren)'s protection.
- \_\_\_\_\_ 7. If a medical emergency arises, the A+ Program will first attempt to contact me. If I cannot be reached, the A+ Program will attempt to contact adults authorized by me in case of emergency, and that if no authorized adults can be reached, appropriate treatment will be secured at the nearest medical facility. If a major illness or injury is involved, my child(ren) will be transported by ambulance to a designated site and/or physician and I am financially responsible for any medical care or transportation incurred on my child(ren)'s behalf.
- \_\_\_\_\_ 8. The A+ Program will operate from close of school to 5:30 p.m. each school day or at another designated time as determined by the site. The program will not operate during school vacations, state holidays, Teacher Institute Day, and school half-days.
- \_\_\_\_\_ 9. Transportation to and from the A+ Program will not be provided. If my child(ren) attends an A+ Program at a school other than his/her regular school, I must make transportation arrangements and assume responsibility for getting my child(ren) to the other school.
- \_\_\_\_\_ 10. It is my responsibility to see that my child(ren) is picked up by the designated closing time.
- \_\_\_\_\_ 11. If my child(ren) is having problems in the program, a conference will be arranged between myself, the staff, and the Site Coordinator.
- \_\_\_\_\_ 12. The A+ Program reserves the right to terminate A+ Program services if it is determined that placement is unsatisfactory.
- \_\_\_\_\_ 13. If weather or other emergency forces the closing of regular school, the A+ Program will also be closed.
- \_\_\_\_\_ 14. If my work/school schedule changes, I must notify the A+ Site Coordinator about the changes.
- \_\_\_\_\_ 15. I am aware and authorize that my child(ren) may participate in physical development/coordination activities during A+.
- \_\_\_\_\_ 16. I understand that my child(ren) will be given an option of alternative activities if they choose not to participate in physical development/coordination activities during A+.

**Fee Procedures: Please initial each of the following certifying that you have read, understand and agree with each item.**

I understand and agree that:

- \_\_\_\_\_ 1. I am responsible for monthly A+ Program tuition.
- \_\_\_\_\_ 2. **I shall pay the monthly tuition when it is due or it must be postmarked before the first school day of each month. Payment for December/January combined months will be paid in December.**
- \_\_\_\_\_ 3. I must not send payments to school with my child(ren), but must bring or mail them to the A+ Program at the school.
- \_\_\_\_\_ 4. The monthly tuition I pay for my child(ren) is a flat rate, and that it does not depend on the number of days my child(ren) actually attends the program.
- \_\_\_\_\_ 5. The A+ Program will make no refunds once tuition is paid for the month even if my child(ren) has attended only part of the month, e.g., even for one day.
- \_\_\_\_\_ 6. I must pay a \$25.00 service charge (cash or money order) for checks that I write to the program that are returned by the bank because of insufficient funds.
- \_\_\_\_\_ 7. I understand that the monthly A+ Program tuition is due on or before the first school day of each month. I shall pay a \$5.00 late charge per family for each school day a payment is overdue. If I do not pay the monthly tuition within the first five (5) A+ Program days of the month, it will result in my child(ren)'s immediate termination from the A+ Program on the sixth (6th) A+ Program day.
- \_\_\_\_\_ 8. Failure to pay any outstanding fees by the end of the month shall result in my child(ren)'s termination from the program.
- \_\_\_\_\_ 9. My child(ren) may re-enroll if I pay all outstanding fees, and a penalty fee of \$25 for reinstatement. If I have more than one child enrolled in the A+ Program, my family is penalized a flat reinstatement fee of \$25.
- \_\_\_\_\_ 10. I will arrange for another authorized adult to pick up my child(ren) if the adult responsible for my child(ren)'s pick-up is to be late. If no other arrangements can be made, I will make every effort to call the school to notify A+ staff of my expected tardiness.
- \_\_\_\_\_ 11. If my child(ren) is picked up late, I will pay a \$5.00 late fee per child for every 15 minutes beyond the closing time, (that is, 1-15 minutes late – \$5.00; 16-30 minutes late – \$10.00, etc.) and that chronic tardiness may result in my child(ren)'s termination from the A+ Program.

I understand and agree to abide by the above parent responsibilities and billing procedures. I understand and agree that my failure to do so may result in termination of my child(ren)'s enrollment in the A+ Program.

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Signature of Parent/Legal Guardian

Date



## DISCLAIMER & CONSENTS

### PARENT / GUARDIAN CONSENT FORM

I hereby agree that, if Kama'aina Kids staff is unable to contact me or one of the persons listed as emergency contact, I hereby consent that if my child exhibits signs of illness or injury, that at the discretion of the Kama'aina Kids supervisor on duty, my child may be taken to the nearest medical facility and be given any examination/treatment that is deemed necessary by the personnel of the medical facility, and if permissible by medical facility, subsequently released to Kama'aina Kids supervisor or staff-in-charge.

I hereby give my child permission to attend and participate in the activities conducted by Kama'aina Kids' A+, Before Care, and Holiday Care programs for the school year noted above.

I hereby authorize Kama'aina Kids to use my child's name and video or photograph at any time and in any manner in connection with its advertising, publicity, and public relations programs. The video-photo may only be used by Kama'aina Kids. No further claims will be made by me.

### DISCIPLINE POLICY

Discipline is used to assure the safety and well-being of all program participants. All children are expected to respect themselves, other people and their property. If a child is not following the guidelines of Kama'aina Kids staff consistent with these expectations, then child will take a "time out" from the activity at the staff member's discretion. A child with continued behavior problems will be sent to the Kama'aina Kids' Program Site Coordinator who may contact the parents for the purpose of removing the child from the program. Kama'aina Kids reserves the right to refuse any child future participation in its programs.

I hereby authorize Kama'aina Kids to exercise these discipline policies in regard to my child.

### CONFIDENTIALITY

I understand that any information in this registration packet will not be disclosed to persons other than Kama'aina Kids staff unless the parents or guardians of the child grant written permission for the disclosure or an emergency arises.

Father/Guardian #1 Signature \_\_\_\_\_ Date \_\_\_\_\_ Mother/Guardian #2 Signature \_\_\_\_\_ Date \_\_\_\_\_

Father/Guardian #1 Email \_\_\_\_\_ Mother/Guardian #2 Email \_\_\_\_\_  
Keep up-to-date on out of school programs and intersession day camps by signing up for our emails.

# A+ PROGRAM EMERGENCY FORM

(This form needs to be completed every school year.)

Father's ID No. \_\_\_\_\_

Mother's ID No. \_\_\_\_\_

School \_\_\_\_\_ Date \_\_\_\_\_

Grade \_\_\_\_\_ Room \_\_\_\_\_ Language Spoken at Home \_\_\_\_\_

Name \_\_\_\_\_ Sex: \_\_\_\_\_ Birthdate \_\_\_\_\_  
(Last) (First) (Middle Initial)

Home Address \_\_\_\_\_ Apt. No. \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Child resides with \_\_\_\_\_

Mailing Address \_\_\_\_\_ Zip Code \_\_\_\_\_

Father/ Legal Guardian's Name _____ Employer _____ Home Phone _____ Bus. Phone _____ Cellular Phone _____ E-mail Address _____	Mother/ Legal Guardian's Name _____ Employer _____ Home Phone _____ Bus. Phone _____ Cellular Phone _____ E-mail Address _____
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**EMERGENCY CONTACTS** In case child listed above becomes ill or is injured at school and I cannot be contacted, the school authorities have my permission to contact and release my child to the custody of one of the following:

Name	Relationship	Phone
1. _____	_____	_____
2. _____	_____	_____

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_ Dentist \_\_\_\_\_ Phone \_\_\_\_\_

If my child needs to be taken to an emergency facility, he/she will be taken to the nearest one. I give my consent for school authorities to take appropriate action for the safety and welfare of my child.

\_\_\_\_\_  
Parent/Legal Guardian's Signature

To assure prompt attention to your child, PLEASE NOTIFY SCHOOL OF ANY CHANGE IN PHONE NUMBER OR ADDRESS.

My child has health insurance: ☐ Yes ☐ No If YES, check: ☐ QUEST ☐ Medicaid **OR** ☐ Private  
If private, check your plan: ☐ HMSA ☐ Kaiser ☐ Tri-Care ☐ Other

• My child receives regular care for the following medical conditions:

☐ No medical condition

☐ Yes. **Please check below:**

- |   |   |  |  |   |
|---|---|--|--|---|
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Chronic Cough/Wheezing | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> JRA Arthritis   | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Behavioral Problems  | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Hemophilia    | <input type="checkbox"/> Rheumatic Heart | <input type="checkbox"/> Skin Problems      |
| <input type="checkbox"/> Cancer/Leukemia  | <input type="checkbox"/> Hearing Problems       | <input type="checkbox"/> Hypertension  | <input type="checkbox"/> Seizures        | <input type="checkbox"/> Vision Problems    |
| <input type="checkbox"/> <b>Allergies:</b> <input type="checkbox"/> Bee Sting <input type="checkbox"/> Food <input type="checkbox"/> Medications <input type="checkbox"/> Other |   |  |  |   |

Date and type of last reaction

☐ Other Health Concerns:

☐ Takes medications (LIST)

• Other children in the household:

Name

School

Grade

# A+ PROGRAM EMERGENCY FORM

(This form needs to be completed every school year.)

Father's ID No. \_\_\_\_\_

Mother's ID No. \_\_\_\_\_

School \_\_\_\_\_ Date \_\_\_\_\_

Grade \_\_\_\_\_ Room \_\_\_\_\_ Language Spoken at Home \_\_\_\_\_

Name \_\_\_\_\_ Sex: \_\_\_\_\_ Birthdate \_\_\_\_\_  
(Last) (First) (Middle Initial)

Home Address \_\_\_\_\_ Apt. No. \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Child resides with \_\_\_\_\_

Mailing Address \_\_\_\_\_ Zip Code \_\_\_\_\_

Father/ Legal Guardian's Name _____ Employer _____ Home Phone _____ Bus. Phone _____ Cellular Phone _____ E-mail Address _____	Mother/ Legal Guardian's Name _____ Employer _____ Home Phone _____ Bus. Phone _____ Cellular Phone _____ E-mail Address _____
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**EMERGENCY CONTACTS** In case child listed above becomes ill or is injured at school and I cannot be contacted, the school authorities have my permission to contact and release my child to the custody of one of the following:

Name	Relationship	Phone
1. _____	_____	_____
2. _____	_____	_____

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_ Dentist \_\_\_\_\_ Phone \_\_\_\_\_

If my child needs to be taken to an emergency facility, he/she will be taken to the nearest one. I give my consent for school authorities to take appropriate action for the safety and welfare of my child.

\_\_\_\_\_  
Parent/Legal Guardian's Signature

To assure prompt attention to your child, PLEASE NOTIFY SCHOOL OF ANY CHANGE IN PHONE NUMBER OR ADDRESS.

My child has health insurance: ☐ Yes ☐ No If YES, check: ☐ QUEST ☐ Medicaid **OR** ☐ Private  
If private, check your plan: ☐ HMSA ☐ Kaiser ☐ Tri-Care ☐ Other

• My child receives regular care for the following medical conditions:

☐ No medical condition

☐ Yes. **Please check below:**

- |  |   |  |  |   |
|--|---|--|--|---|
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Chronic Cough/Wheezing | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> JRA Arthritis   | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Hemophilia    | <input type="checkbox"/> Rheumatic Heart | <input type="checkbox"/> Skin Problems      |
| <input type="checkbox"/> Cancer/Leukemia     | <input type="checkbox"/> Hearing Problems       | <input type="checkbox"/> Hypertension  | <input type="checkbox"/> Seizures        | <input type="checkbox"/> Vision Problems    |

☐ **Allergies:** ☐ Bee Sting ☐ Food ☐ Medications ☐ Other

Date and type of last reaction

☐ Other Health Concerns:

☐ Takes medications (LIST)

• Other children in the household:

Name

School

Grade

# A+ PROGRAM EMERGENCY FORM

(This form needs to be completed every school year.)

Father's ID No. \_\_\_\_\_

Mother's ID No. \_\_\_\_\_

School \_\_\_\_\_ Date \_\_\_\_\_

Grade \_\_\_\_\_ Room \_\_\_\_\_ Language Spoken at Home \_\_\_\_\_

Name \_\_\_\_\_ Sex: \_\_\_\_\_ Birthdate \_\_\_\_\_  
(Last) (First) (Middle Initial)

Home Address \_\_\_\_\_ Apt. No. \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Child resides with \_\_\_\_\_

Mailing Address \_\_\_\_\_ Zip Code \_\_\_\_\_

Father/ Legal Guardian's Name _____	Mother/ Legal Guardian's Name _____
Employer _____	Employer _____
Home Phone _____ Bus. Phone _____	Home Phone _____ Bus. Phone _____
Cellular Phone _____	Cellular Phone _____
E-mail Address _____	E-mail Address _____

**EMERGENCY CONTACTS** In case child listed above becomes ill or is injured at school and I cannot be contacted, the school authorities have my permission to contact and release my child to the custody of one of the following:

Name	Relationship	Phone
1. _____	_____	_____
2. _____	_____	_____

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_ Dentist \_\_\_\_\_ Phone \_\_\_\_\_

If my child needs to be taken to an emergency facility, he/she will be taken to the nearest one. I give my consent for school authorities to take appropriate action for the safety and welfare of my child.

\_\_\_\_\_  
Parent/Legal Guardian's Signature

To assure prompt attention to your child, PLEASE NOTIFY SCHOOL OF ANY CHANGE IN PHONE NUMBER OR ADDRESS.

My child has health insurance: ☐ Yes ☐ No If YES, check: ☐ QUEST ☐ Medicaid **OR** ☐ Private  
If private, check your plan: ☐ HMSA ☐ Kaiser ☐ Tri-Care ☐ Other

• My child receives regular care for the following medical conditions:

☐ No medical condition

☐ Yes. **Please check below:**

- |  |   |  |  |   |
|--|---|--|--|---|
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Chronic Cough/Wheezing | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> JRA Arthritis   | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Hemophilia    | <input type="checkbox"/> Rheumatic Heart | <input type="checkbox"/> Skin Problems      |
| <input type="checkbox"/> Cancer/Leukemia     | <input type="checkbox"/> Hearing Problems       | <input type="checkbox"/> Hypertension  | <input type="checkbox"/> Seizures        | <input type="checkbox"/> Vision Problems    |

☐ **Allergies:** ☐ Bee Sting ☐ Food ☐ Medications ☐ Other

Date and type of last reaction

☐ Other Health Concerns:

☐ Takes medications (LIST)

• Other children in the household:

Name

School

Grade