

Reg. Fee: \$ \_\_\_\_\_  
Check/Money Order #: \_\_\_\_\_



2021-2022  
Montgomery County Schools District Child Care Program  
Child Care Application

**Student's Name:** \_\_\_\_\_  
Last First Middle/Nickname

**Parent/Guardian's Names** (please list both parent/guardian names if applicable): \_\_\_\_\_

Mailing Address: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

School: \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_

AM Child Care (cost is additional): Yes \_\_\_ NO \_\_\_ List Siblings enrolled in the program: \_\_\_\_\_

**Annual Registration Fee:** \$20.00 per family (please submit check or money order with this application)

**\*\*If you have legal documents regarding custody of your child(ren) that prevents a parent/guardian from pick up please attach a copy with your application.**

Home Phone # \_\_\_\_\_ Mom's Cell # \_\_\_\_\_ Dad's Cell # \_\_\_\_\_

Mothers Work # \_\_\_\_\_ Supervisor/Ext: \_\_\_\_\_ Place of Employment \_\_\_\_\_

Fathers Work # \_\_\_\_\_ Supervisor/Ext: \_\_\_\_\_ Place of Employment \_\_\_\_\_

**List four other persons who should be contacted in case of an emergency and/or to pick-up your child.**  
(Aside from parent/guardians, only people listed below will be permitted to pick your child up from the after-school program)

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Phone # \_\_\_\_\_ Cell # \_\_\_\_\_

Phone # \_\_\_\_\_ Cell # \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Phone # \_\_\_\_\_ Cell # \_\_\_\_\_

Phone # \_\_\_\_\_ Cell # \_\_\_\_\_

We/I authorize any of the persons listed above as contacts to pick my child up from the District Child Care Program. I understand that anyone not listed above **WILL NOT** be permitted to pick my child up without written consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Mother, Father, or Legal Guardian

The Montgomery County School System and/or staff will not be held responsible for any expense or liability incurred by accident or illness beyond that covered by insurance that is carried by the school system. Students, their parents, and employees of the Montgomery County Board of Education are hereby notified this school district does not discriminate on the basis of race, color, national origin, age, religion, marital status, sex or handicap in employment, educational programs, vocational programs, or activities set forth in Title IX, Title VI, & Section 504. Any person having inquiries concerning the above is directed to Richard Culross, Montgomery County Board of Education, 3400 Indian Mound Drive Mt. Sterling, KY 40353/859-497-8760.

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**EMERGENCY MEDICAL INFORMATION**

List physical handicaps, restrictions, and/or impairments: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Pediatrician: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_

Is your child allergic to any medication or foods? Yes \_\_\_\_\_ NO \_\_\_\_\_ if so, please list \_\_\_\_\_

Medical Conditions, if any: \_\_\_\_\_

Medications child is taking: \_\_\_\_\_

If your child needs to take medications during child care hours, you must fill out a Medication Form for each day that the medication needs to be given. All medication must be in original containers, with up to date information provided on the label. Please ask site supervisor if you need more detail regarding the medication form.

**\*\*A copy of your child's current up-to-date immunization MUST be provided to the site-supervisor within 30 days of your child's enrollment.**

**CONSENT FOR MEDICAL/SURGICAL CARE/EMERGENCY TREATMENT  
AND CHILD'S MEDICAL INFORMATION**

In presenting my son/daughter for diagnosis and treatment

Name: \_\_\_\_\_ for \_\_\_\_\_  
 Mother       Father       Legal Guardian       Son       Daughter

Of \_\_\_\_ years of age; hereby voluntarily consent to the rendering of such care, including diagnostic procedures, surgical and medical treatment, and blood transfusions, by authorized members of the hospital staff or their designees, as may in their professional judgment be necessary. I acknowledge that no guarantees that have been made to me as to the effect of such examination or treatment on child's condition.

I hereby give my consent to Montgomery County Schools District Child Care Program who will be caring for our child \_\_\_\_\_ for the period AUGUST 2021 to AUGUST 2022, to arrange for routine or emergency medical/surgical/dental care and treatment necessary to preserve the health of my child.

I acknowledge that I am responsible for all reasonable charges in connection with the care and treatment rendered during this period. Initial: \_\_\_\_\_

I agree that I have read the entirety of this form, and certify that I understand its content. Initial: \_\_\_\_\_

I have been given a copy of the District Child Care handbook, as well as the 2021-2022 Fee Schedule. I understand my rights and obligations as a parent, and agree to the terms and conditions outlined by the program. In the event that I withdraw my child from the program, I agree to give the District Child Care Staff proper notice prior to doing so. I understand that failure to do so could result in additional fees being charged to my account. I agree to discuss the rules and regulations of the program with my child so that he/she understands the expectations of the child care program.

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**