

Welcome to the Eglin School Age Care Program!

You have been offered care for your child and we look forward to having them. Below you will find some helpful information when you are filling out the registration packet.

- * On the AF Form 1181 please make sure all blocks are filled out (you do not need to fill out the shot record portion)
- * Ensure your emergency contact person is local and has base access and also place their name in the authorized to sign out block
- * The authorization for field trips block is a signature
- * Please bring in a current shot record that reflects a flu vaccination for the current flu season
- * On the DD Form 2652 only fill out the highlighted portions and attach the most recent pay statements for everyone in the household to include any retirement/disability pay. If your spouse is a student school enrollment verification from the school registrar office is required.

****If your child has special needs a separate packet must be accomplished by your child's physician. Asthma, Allergies or any Chronic Illness also require additional forms to be completed by your child's physician. All documents will need to be submitted to our Coordinator prior to enrollment. All medical documents will be submitted to our Medical Advisor and Flight Chief for approval, we must have approval prior to your child's start date. Please ensure you allow enough time to accomplish and return to the program.**

Eglin Youth Programs Before and After School Program

Weekly Contract – School Year 2019-2020

SELECT CARE NEEDED: ☐ Before & After School ☐ Before School Only ☐ After School Only

CHILD'S NAME: _____
(Last) (First) (M.I.)

SCHOOL CHILD ATTENDS:_____ GRADE:_____ START DATE:_____

Optional: Ethnicity () Asian/Pacific () Native American/Alaskan Native () African American, not Hispanic () Caucasian, not Hispanic () Hispanic () other

****This information is used for 4H, Boys and Girls Club, USDA and School Age Accreditation applications. ****

PLEASE INITIAL EACH ITEM BELOW:

_____ 1. CALENDAR/HOURS OF OPERATION/LATE PICK-UP: The program follows the Okaloosa County School Calendar. Hours of operation are as follows:

Before&After School 0600-0800 & 1430-1800, Mon-Fri
School Holidays: 0600-1800

 2. NON-SCHOOL DAYS: I understand if my child(ren) attends a private school that does not follow the Okaloosa County School Calendar I must make other arrangements for care on those non-school and early release days.

*******IMPORTANT REMINDER*******

3. Last day of the Before & After School Contract will be Friday May 29 2020. The program will be closed on Friday 22 May 2020 for an AFMC Family Day, please make appropriate arrangements.

The program closes on all Federal Holidays, base closure days and the day after Thanksgiving (29 November 2019).

4. Updated Shot record showing an Influenza immunization within the last year is required for attendance in the program.

A late pick-up fee of \$2.00 per minute will be assessed for the starting at 1801. **THERE IS NO GRACE PERIOD FOR LATE PICK UP.** Security Forces will be contacted for assistance in locating parents if the program is unable to contact parents or the designated emergency person by 1815.

5. FEES: Fees are based on total household income. The most recent Leave and Earnings Statement (LES) for military and proof of all non-military members' income living in the household are necessary for income verification. In cases where one adult member of the household is enrolled in school with no income, proof of full-time student status as defined by the school is required at the time of enrollment. Proof of continued enrollment is required at the beginning of each semester/quarter to remain eligible for care. If you do not wish to disclose your total family income, you are not required to do so; **however, your fees will be automatically set at the highest fee category.**

6. **PAYMENTS: WEEKLY FEES ARE DEBITED AUTOMATICALLY WITH THE CHASE PAYMENTTECH SYSTEM.** Partial payment will not be accepted. If the credit/debit card is declined a \$5.00 per business day per family fee will be assessed and if immediate payment is not received, your child (ren) will be withdrawn from the program.

Note: The Thanksgiving, Winter, Spring Break and Summer weeks are an option to attend or not attend and is not included in the annualized fee structure. If you choose to attend during these weeks you will be charged the full weekly fee determined by your fee category. You will be required to register and fill out an additional contract at the designated timeframe for those programs.

_____ **7. NOTICE OF WITHDRAWAL/TERMINATION:** Written notice of withdrawal must be submitted 2 weeks in advance of the date of withdrawal. Failure to comply will result in a charge for two weeks of care. The program may terminate enrollment of any child for just cause, such as continual behavior problems adversely affecting other children, children who physically harm other children or staff and/or children who are an elopement risk or unable to follow the guidance/discipline policy.

_____ **8. HEALTH AND HYGIENE:** Parents/Guardians must respond within a reasonable amount of time (1 hour) to calls regarding their child's health. Children will be excluded from care for illnesses based on the American Academy of Pediatrics standards.

_____ **9. BEHAVIOR PROBLEMS:** Parents will be notified if a child is engaging in unsafe/negative behaviors towards themselves or others. Examples are: using abusive/profane language, stealing or exhibiting uncontrollable behavior (tantrums, throwing objects, hitting staff members or children, etc). You will be notified to pick up your child within 1 hour of being contacted. Behavior problems that persist may result in termination of enrollment and the contract will be void.

_____ **10. INTAKE AND ENROLLMENT:** AFI 34-144 15.2 page 143 states when applying for care, registering for a program or currently participating, if a child/youth is identified as having a disability, medical condition or specific need, CYP personnel will work with the family to determine if an Inclusion Action Team (IAT) meeting is needed. The case will be reviewed as soon as possible to ensure environments, accommodations and any training required are in place before the child/youth starts. Therefore, any child who has a physical or mental impairment that substantially limits one or more life activities must complete a Special Needs Package to include a medical profile and a medical consent form. This package will be presented to the Medical Advisor and/or Flight Chief for consideration for enrollment into the program to ensure the program can reasonably accommodate and/or meet the needs of the child. ***Failure to disclose any medical conditions, behavioral problems and/or developmental delays could result in dismissal from the program. Re-enrollment into the program will be evaluated by the Medical Advisor and/or Flight Chief after review of the necessary paperwork.***

_____ **11. MEDICATION:** If your child needs medication while enrolled in the School Age Program, complete AF Form 1055 daily indicating when medications are to be administered. Medications will not be administered if the AF Form 1055 has not been initialed for that particular day. If authorization has not been given, the parent will be notified by phone to receive authorization and it will be annotated on the AF Form 1055. Prescriptions must be current (within 90 days of the date filled). All medications must be in the original container with the name of physician, date filled, prescription number, child's name, dosage amount/frequency and end date (ex. Use for 10 days or until completed).

_____ **12. DRESS AND PERSONAL ITEMS:** Due to safety reasons, youth must wear closed-toed shoes and a strap around the back of the ankle while in the program, no flip flops are allowed. Parents will be notified if proper shoes are not worn and will be asked to provide suitable footwear. A change of clothing in case of accidents is strongly encouraged and can be kept in your child's cubby. All items must be marked with first/last name in permanent ink. Youth are not allowed to wear tight and/or revealing clothing, i.e. halter/tube tops etc. Personal items such as toys or valuables are not permitted in the program. The School Age Program is not responsible for lost, damaged or stolen clothing or personal items.

_____ **13. DROP OFF/PICK UP:** Parents, legal guardians, or persons designated by the sponsor on the AF 1181 must drop the children off and sign them in if under age 9, and/or pick them up and sign them out from the program. We will not release a child to an older sibling unless they are 14 years of age or older and are listed on the AF Form 1181. ***PLEASE NOTIFY THE PROGRAM IF YOUR CHILD WILL BE ABSENT FROM THE PROGRAM.***

_____ **14. FOOD:** All food and beverages will be provided at or for the program IAW DoD, AF and USDA CACFP requirements to include amount and type of food. If your child has a food allergy or is not allowed certain foods for religious reasons, we will make the appropriate substitution (if possible). This request must be supported by written documentation by a physician or religious affiliate clearly outlining the restricted foods, why they are restricted and approved by management in advance.

_____ **15. INFORMATION UPDATES:** Patrons are to ensure the program is informed of any changes in address, phone number, employment location, emergency contact, email address or changes in family status that affect the child's well-being. The School Age Program uses the blackboard system as the main contact for information and events regarding the program and email as the main contact regarding information pertaining to your account. Please ensure the office has an

update email address on file for your family. Facebook and Twitter will also be used for marketing information regarding the program.

16. **COMMUNITY AFFILIATIONS:** My child has my permission to participate in all 4H, Boys and Girls Club, Power Hour activities and program field trips as offered. My child may be photographed and utilized for advertising or marketing program events.

17. Chain of command information and detailed emergency preparedness procedures are available to patrons upon request.

18. **SPACE AVAILABLE:** If there is a waiting list and you are enrolled in the program as a Space Available Patron (Contractor, Non-Working Spouse, Retiree) you will be given 30 days' notice to vacate your space in the program if another patron with a higher priority needs care. (AFI 34-144, 11.8.4.1)

19. This agreement is subject to change and notification will be provided in advance. This agreement expires at the end of the Before & After School Program, Thursday 28 May 2020. If you require care for Summer Camp you must register at the designated established timeframe.

Photo Release: I give the Eglin School Age Program permission to take photos of my child to be used on bulletin boards, newsletters, program Facebook page and any other Eglin publications used by our program.

Parent/Guardian Signature Date

Transportation: I give the Eglin School Age Program permission to transport my child to and from Eglin Elementary and on designated field trips during full time break programs. If your child attends a private school please verify with the school on transportation. Children who are on a waiver to attend Lewis School will have a transportation fee, please contact the Youth Center at 882-8212 for additional information and cost.

Parent/Guardian Signature Date

***** For children 9-12 years old only**
I give permission for my child to sign him/herself in and out of the Eglin School Age Program. Once a child has signed out from the program they are no longer considered a part of the program for that particular day and School Age Program staff are no longer responsible for the care of your child. Please ensure your child is signing in/out of the program on a daily basis, failure to sign in/out could result in the parent/guardian needing to sign the child in/out of the program.

Parent/Guardian Signature Date

I, the undersigned sponsor, consent to collection by military pay authorization (MPO) of any amount due to the United States Government or its instrumentalities in the amount of any indebtedness to the Eglin School Age Program if not paid within two weeks after notification that such amounts are due. *I have read and agree to all terms set forth in this enrollment agreement and policies established, and I understand that I will be responsible for making the payments on my account regardless of my child's attendance at the School Age Program. This contract is subject to change with proper notification.*

(Signature)

(Date)

(Program Representative)

(Date)

AIR FORCE YOUTH FLIGHT PROGRAM PATRON REGISTRATION

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 8013; 44 USC 3101; EO 9397

PRINCIPAL PURPOSES: To provide Youth Flight Programs with authorization for medical treatment in emergency situations; authorization for field trips; identify children and sponsor, record required immunizations; record known allergies; record income data; record special needs requirements; and record special instructions.

ROUTINE USES: Form may be furnished to civilian doctors or hospitals in course of obtaining emergency medical attention for children. Information furnished may be disclosed, upon request, to other Federal, state or local governmental agencies in the pursuit of their official duties. Finally, it may be used for other lawful purposes including law enforcement and litigation.

DISCLOSURE IS VOLUNTARY: Failure to furnish information, including SSN, will result in denial of admission of child(ren) to Youth Flight Programs. SSN is used for positive identification of individuals and records.

CHILD'S NAME	SPONSOR (Last, First, Middle Initial)	SPOUSE (Last, First, Middle Initial)	FEES
HOME PHONE	RANK/GRADE	RANK/GRADE	DEROS/ID EXPIRES
ADDRESS	DUTY PHONE	DUTY PHONE	BRANCH OF SERVICE
	ORGANIZATION	EMERGENCY CONTACT	EMERGENCY PHONE
MARITAL STATUS	SPONSOR'S SSN	SPOUSE'S SSN	HOSPITAL PHONE
			PHYSICIAN'S NAME

VACCINE / DATE RECEIVED	BIRTH	2 MOS	4 MOS	6 MOS	12 MOS	15 MOS	18 MOS	4-6 YRS	11-12 YRS	14-16 YRS	SEX (X One)	MALE FEMALE	DATE OF BIRTH (Day, Month, Year)
Hepatitis B													I authorize emergency treatment for the children named hereon:
1st	Hep B-1												
2nd													
3rd		Hep B-2	Hep B-3						Hep B				
4th													
Diphtheria-Tetanus, Pertussis													SIGNATURE _____ DATE (YYYYMMDD) _____
1st													
2nd													
3rd		DTP	DTP	DTIP	DTP			DTP OR DTAP	Td				
4th													
5th													
6th													
H. Influenzae type b													SPECIAL INSTRUCTIONS
1st													
2nd													
3rd		Hib	Hib	Hib	Hib								
4th													
Polio													SPECIAL NEEDS CARE / CHRONIC ILLNESSES / ALLERGIES
1st													
2nd													
3rd		OPV	OPV	OPV				OPV					
4th													
Measles, Mumps, Rubella													
1st					MMR			MMR OR MMR					
2nd													
Vaccella Zoster Virus Vaccine													
1st					VZV			VZV					
2nd													

OTHER IMMUNIZATIONS AS REQUIRED:	NAMES OF ADDITIONAL CHILDREN ENROLLED IN PROGRAM:	ADULTS AUTHORIZED TO SIGN CHILDREN IN / OUT
VACCINE TYPE: _____ DATE: _____		
VACCINE TYPE: _____ DATE: _____		
VACCINE TYPE: _____ DATE: _____		
VACCINE TYPE: _____ DATE: _____		
FAMILY INCOME (Adjusted gross--most recent 1040): PROVIDE ONLY IF REDUCED FEES ARE REQUESTED. \$ _____ SINGLE / DUAL INCOME (Circle One) \$ _____		AUTHORIZATION FOR FIELD TRIPS
PARENT SIGNATURE _____		IT IS THE RESPONSIBILITY OF EACH SPONSOR TO ENSURE IMMUNIZATIONS AND EMERGENCY INFORMATION IS UP TO DATE. FAILURE TO UPDATE MAY RESULT IN REFUSAL OF SERVICE.

APPLICATION FOR DEPARTMENT OF DEFENSE CHILD CARE FEES

(Read Instructions on back before completing form.)

OMB No. 0704-0515
OMB approval expires
May 31, 2017

The public reporting burden for this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Information Management Division, 4800 Mark Center Drive, Alexandria, VA 22350-3100 (0704-0515). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS. RETURN COMPLETED FORM TO THE APPROPRIATE CHILD AND YOUTH PROGRAM REPRESENTATIVE.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 3013, Secretary of the Army; 10 U.S.C. 5013, Secretary of the Navy; 10 U.S.C. 5041, Headquarters, Marine Corps; 10 U.S.C. 8013, Secretary of the Air Force; DoD Instruction 6060.02, Child Development Programs; Army Regulation 608-10, Child Development Services; OPNAV Instruction 1700.9 series, Child and Youth Programs; Marine Corps Order P1710.30E, Children, Youth, and Teen Program (CYTP); Air Force Instruction 34-248, Child Development Programs; and Air Force Instruction 34-249, Youth Programs, and 34-276, Family Child Care.

PRINCIPAL PURPOSE(S): To collect total family income to determine child care fees. When completed, records are covered by one of the appropriate SORNs: Department of the Army: <http://dpclo.defense.gov/privacy/SORNsIndex/tabid/5915/article/6160/a0608-10-cfsc.aspx>;

Department of the Navy: <http://dpclo.defense.gov/privacy/SORNsIndex/tabid/5915/article/6527/nm01754-3.aspx>;

Department of the Air Force: <http://dpclo.defense.gov/privacy/SORNsIndex/DODwideSORNArticleView/tabid/6797/Article/5793/f034-af-sva-c.aspx>

ROUTINE USE(S): Department of the Army records may be disclosed to civilian health and welfare departments/agencies in emergencies.

Department of the Navy records may be disclosed to local, state and Federal officials involved in child care services, if required, in the performance of their official duties relating to child abuse reporting and investigations. Department of the Air Force records may be disclosed to civilian health and welfare departments/agencies in emergency situations.

DoD Blanket Routine Uses 1 (Law Enforcement), 4 (Congressional Inquiries), 6 (Required by International Agreement), 9 (Department of Justice for Litigation), 12 (National Archives and Records Administration), and 15 (Data Breach Remediation) specifically apply to this system. Other DoD Blanket Routine Uses found at <http://dpclo.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx> may apply to these records. Any release under a blanket routine use will be compatible with the purpose of the collection.

DISCLOSURE: Voluntary; however, failure to furnish all requested information will result in application of the highest fee range.

SECTION I - DEPENDENT CHILDREN

1. NAME OF EACH CHILD (LAST, First, Middle Initial)	2. DATE OF BIRTH (YYYYMMDD)	3. AGE	4. CARE REQUESTED (OR ENROLLED)
a.			
b.			
c.			
d.			
e.			

SECTION II - ANNUAL FAMILY INCOME

5. SPONSOR				
a. NAME (LAST, First, Middle Initial)			b. YEARS OF MILITARY/CIVIL SERVICE	
c. INCOME				
(1) Income Data	(2) Basic Allowance for Housing (BAH)	(3) Basic Subsistence Allowance	(4) Other Earned Income	(5) Total Income - Sponsor (To be completed by Program Staff)
6. SPOUSE OR OTHER ADULT LIVING IN THE HOME				
a. NAME (LAST, First, Middle Initial)			b. INCOME	
7. OTHER EARNED INCOME			8. TOTAL INCOME (Include income from Blocks 5, 6, and 7. To be completed by Program Staff.)	

SECTION III - CERTIFICATION OF SPONSOR/DESIGNEE

(Required for Category I - IX. Please read the following statement carefully before signing.)

I certify that all of the above information is true and correct and that all family income of the spouse and sponsor is reported. I understand that this information is being given in order to determine child care fees to be paid and that Federal funds are used to subsidize the cost of child care. I also understand that the installation commander may verify the information on the application; and that deliberate misrepresentation of this information may subject me to prosecution under applicable State and Federal laws. See 18 U.S.C. Section 1001.

9. SIGNATURE OF SPONSOR	10. SIGNATURE OF SPOUSE	11. DATE SIGNED (YYYYMMDD)

SECTION IV - FOR CHILD DEVELOPMENT PROGRAM USE ONLY

12. CATEGORY OF APPROVAL	13. AUTHORIZED FEES	14. DATE OF APPROVAL (YYYYMMDD)	15. NAME OF CHILD DEVELOPMENT PROGRAM OFFICIAL

INSTRUCTIONS

Per Department of Defense Instruction 6060.02, Child Development Programs, this form is utilized to determine fees for DoD Child Care Programs.

To determine child care fees for your child(ren), or and child(ren) you legally claim as dependents, this form must be completed, signed and returned to the facility for which your child is enrolling.

Fees are determined based on your Total Family Income (TFI) as defined below. If you choose not to disclose your family income, your rate for child care will be set at the highest fee level.

Total Family Income (TFI) - For the purpose of determining child care fees in DoD Child Development Programs, total family income is defined as all earned income including wages, salaries, tips, special duty pay (flight pay, active duty demo pay, sea pay) and active duty save pay, long-term disability benefits, voluntary salary deferrals, retirement or other pension income including SSI paid to the spouse and VA benefits paid to the surviving spouse before deductions for taxes. TFI calculations must also include quarters subsistence and other allowances appropriate for the rank and status of military or civilian personnel whether received in cash or in kind.

DO NOT INCLUDE alimony, and child support received by the custodial parent, SSI received on behalf of the dependent child, reimbursements for educational expenses or health and wellness benefits, cost of living (COLA) received in high cost areas, temporary duty allowances, or reenlistment bonuses.

For households in which unmarried couples or pairs are living as a family, the income for both adults should be used to determine Total Family Income (TFI).

Sections I, II, and III are to be completed by the sponsor or their designee.

Section I.

1. Provide the last name, first name and middle initial for each child who is receiving care in a DoD child care program.
2. Provide the date of birth for each child who is receiving care in a DoD child care program.
3. Provide the age of each child on the date of application who is receiving care in a DoD child care program.
4. Provide the type of care being request or in which each child is currently enrolled.

Section II.

When completing Section II, include all military and civilian income for both the sponsor and spouse or other adult living in the home.

- 5.a. Provide the sponsor's last name, first name and middle initial.
- 5.b. Provide the total years of military/civilian service as applicable.
- 5.c.(1) Provide your most recent income data and indicate if income is received weekly, biweekly, monthly or twice per month.
- 5.c.(2) Provide the current year BAH RT/C. For dual military living in government quarters include BAH RC/T of the senior member only; in locations where military members receive less than the BAH RC/T allowance, use the local BAH rate; for Defense civilian OCONUS include either the housing allowance or the value of the in-kind housing.
- 5.c.(3). Provide the basic subsistence allowance or in-kind equivalent.
- 5.c.(4) Provide any other earned income.
- 5.c.(5) To be completed by program staff.
- 6.a. Provide the last name, first name and middle initial of the spouse or other adult living in the home, who contributes to the welfare of the child.
- 6.b. Provide the income of the spouse or other adult living in the home, who contributes to the welfare of the child.
7. Provide any additional income.
8. To be completed by program staff.

Section III.

9. Provide the sponsor's signature.
10. Provide the spouse's or other resident adult's signature.
11. Provide the date of signatures.

EGLIN CHILD & YOUTH PROGRAMS PRE-ENROLLMENT HEALTH SCREENING

Identification of Child/Youth's Condition/Restrictions

Does your child/youth have any of the following conditions/restrictions? Please check yes or no.

Child _____ DOB _____

Intellectual Disability ☐ No ☐ Yes

Hearing and/or Visual Impairment ☐ No ☐ Yes

Speech-Language Impairment ☐ No ☐ Yes

Emotional Disturbance ☐ No ☐ Yes

Autism Spectrum Disorder ☐ No ☐ Yes

Orthopedic Impairment ☐ No ☐ Yes

Learning Disability ☐ No ☐ Yes

Multiple Disabilities ☐ No ☐ Yes

List: _____

List Medications/Treatments: _____

Food/Environmental Allergy(ies) ☐ No ☐ Yes

List: _____

Developmental Delay ☐ No ☐ Yes

Attention Deficit Hyperactivity Disorder ☐ No ☐ Yes

Behavioral Disorder ☐ No ☐ Yes

Asthma ☐ No ☐ Yes

Other Chronic Disease or Illness ☐ No ☐ Yes

(Examples include, but are not limited to: Epilepsy,
Heart Condition, Diabetes, Sickle Cell Disease)

List Other: _____

Is your child enrolled in an Exceptional Family Member Program? ____Yes ____No

DISCLOSURE

Voluntary; however, placement and/or care for your child could be delayed/suspended if information is falsified or intentionally omitted on enrollment documentation. Additional paperwork is required and under specific circumstances required paperwork must be reviewed by the CYP Medical Advisor and Inclusion Action Team prior to enrollment.

Printed Name and Signature of Parent/Guardian

Date (MMDDYYYY)

Please sign and date indicating that the information above is accurate and complete to the best of your knowledge.

Eglin School Age Care for School Year 2019-2020

Payment Authorization Form

Per AFMC AFSVA/SSC all child care payments for School Age Care will be made electronically.

You authorize regularly scheduled charges to your Visa or MasterCard. You will be charged each billing period for the total amount due for that period. A charge from Chase Paymentech will appear on your credit/debit card statement.

Please complete the information below:

I _____ authorize Chase Paymentech to charge my credit/debit card indicated below for 1 week of care at a time beginning 9 August 2019.

9, 16, 23, 30 Aug 19 6,13,20,27 Sept 19 4,11,18,25 Oct 19 1,8,15,29 Nov 19 6,13 Dec 19 3,10,17,24,31 Jan 20
7,14,21,28 Feb 20 6,20,27 Mar 20 3,10,17,24 Apr 20 1,8,15,22 May 20

* Thanksgiving, Winter, Spring and Summer Breaks are not included in the Auto Pay Program and are a separate registration.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard

Cardholder Name _____

Account Number _____

Expiration Date _____ CVV (3 digit number on back of card) _____

I authorize the above named business to charge the credit/debit card indicated in this authorization form according to the terms outlined above. I understand that this authorization will remain in effect until I cancel it in writing and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. Furthermore, I understand if the card is declined the sponsor is responsible for immediate payment and late fees may be assessed. I understand that this payment authorization is for the payment of School Age Care fees. I certify that I am an authorized user of this credit/debit card and that I will not dispute the scheduled payments with my credit/debit card company provided the transactions correspond to the terms indicated in this authorization form.

SIGNATURE _____ DATE _____

Parents/Guardians: Our program sends out notifications regarding the program through email and the use of the Blackboard automated notification system. Please fill out the following information so we have the most up to date and current information, please notify the program of any changes. **If you child will be absent from the program please notify the program by 0800 for Before Care and by 1400 for After Care, if it is a full day please notify our program by 0900 if your child will not be in attendance.**

Child/Children's Name(s)_____

Sponsor/Guardian Name_____

Sponsor/Guardian cell_____

Sponsor/Guardian email_____

Spouse Name_____

Spouse cell_____

Spouse email_____

I consent to be notified via the Blackboard system using the following:

☐ Phone

☐ Email

☐ Text

(If all methods are selected you will be notified three times)

Sponsor/Guardian signature

Date

Staff use only:

Cat:_____ Branch:_____

Staff Initials:_____

Procure:_____



Child Care Food Program

Child Participation Form

Name of Child: _____ Name of Facility: Eglin AFB School Age Care

Dear Parent:

Please fill out the following information so that your child may participate in the Child Care Food Program, which reimburses child care providers for serving nutritious, well-balanced meals to children in child care.

If child care hours are the same every day, please complete this chart.

Day	Normal Hours in Care	Meals Normally Received While in Care		
Mon – Fri	<u>0600</u> a.m. to <u>1800</u> p.m.	Breakfast <input checked="" type="checkbox"/>	AM Snack <input type="checkbox"/>	Lunch <input checked="" type="checkbox"/>
		PM Snack <input checked="" type="checkbox"/>	Supper <input type="checkbox"/>	Eve Snack <input type="checkbox"/>

OR

If child care hours are not the same every day, please complete this chart.

Monday	_____ a.m. to _____ a.m. _____ p.m. to _____ p.m.	Breakfast <input type="checkbox"/>	AM Snack <input type="checkbox"/>	Lunch <input type="checkbox"/>
		PM Snack <input type="checkbox"/>	Supper <input type="checkbox"/>	Eve Snack <input type="checkbox"/>
Tuesday	_____ a.m. to _____ a.m. _____ p.m. to _____ p.m.	Breakfast <input type="checkbox"/>	AM Snack <input type="checkbox"/>	Lunch <input type="checkbox"/>
		PM Snack <input type="checkbox"/>	Supper <input type="checkbox"/>	Eve Snack <input type="checkbox"/>
Wednesday	_____ a.m. to _____ a.m. _____ p.m. to _____ p.m.	Breakfast <input type="checkbox"/>	AM Snack <input type="checkbox"/>	Lunch <input type="checkbox"/>
		PM Snack <input type="checkbox"/>	Supper <input type="checkbox"/>	Eve Snack <input type="checkbox"/>
Thursday	_____ a.m. to _____ a.m. _____ p.m. to _____ p.m.	Breakfast <input type="checkbox"/>	AM Snack <input type="checkbox"/>	Lunch <input type="checkbox"/>
		PM Snack <input type="checkbox"/>	Supper <input type="checkbox"/>	Eve Snack <input type="checkbox"/>
Friday	_____ a.m. to _____ a.m. _____ p.m. to _____ p.m.	Breakfast <input type="checkbox"/>	AM Snack <input type="checkbox"/>	Lunch <input type="checkbox"/>
		PM Snack <input type="checkbox"/>	Supper <input type="checkbox"/>	Eve Snack <input type="checkbox"/>
Saturday	_____ a.m. to _____ a.m. _____ p.m. to _____ p.m.	Breakfast <input type="checkbox"/>	AM Snack <input type="checkbox"/>	Lunch <input type="checkbox"/>
		PM Snack <input type="checkbox"/>	Supper <input type="checkbox"/>	Eve Snack <input type="checkbox"/>
Sunday	_____ a.m. to _____ a.m. _____ p.m. to _____ p.m.	Breakfast <input type="checkbox"/>	AM Snack <input type="checkbox"/>	Lunch <input type="checkbox"/>
		PM Snack <input type="checkbox"/>	Supper <input type="checkbox"/>	Eve Snack <input type="checkbox"/>

☐ Check here if your child has no regularly scheduled hours of care

Signature of Parent/Guardian: _____ Date: _____

Printed Name: _____ Phone Number: _____

MEMORANDUM:

FROM:

[Insert name of installation, school, camp, facility]

SUBJECT: Child and Youth Behavioral Military & Family Life Counselor

1. This letter is to inform you about the Child and Youth Behavioral Military and Family Life Counseling (CYB-MFLC) program services. Due to the unique challenges faced by military families, the Department of Defense is offering this private and confidential non-medical counseling service to military service members, military families, and military family service member's children in Child and Youth Programs, Department of Defense Education Activity schools, Local Education Agencies, DoDEA CYP summer programs, National Military Family Association Operation Purple Camps, Guard/Reserve camps, and Operation Military Kids Camps.
2. The CYB-MFLC counselors may support the centers, schools, summer programs and camps and work with military children and their families in the following ways:
 - Observe, participate and engage in activities with children and youth.
 - Provide direct interaction with military children.
 - Model behavioral techniques and provide feedback.
 - Suggest courses of age appropriate behavioral interventions to enhance coping and behavioral skills.
 - Provide outreach to military parents when they are available such as when they drop off or pick up their children or at family events.
 - Be available for military parents to contact for guidance and support.
 - Facilitate psycho-educational groups.
 - Conduct training for staff and parents.
 - Recommend referrals to military family programs and other resources as needed.
3. The counselor may assist military parents, military children and centers with the following type of issues:
 - Communication
 - Self-esteem/self-confidence
 - Resolving conflicts
 - Behavioral management techniques
 - Bullying
 - Helping children deal with angry feelings
 - Sibling/parental relationships
 - Deployment and reintegration issues
4. The counselor may also work with military children in settings such as field trips and other center, camp, or school sponsored activities.

5. The counselor is available to accommodate appointments and meetings/activities after hours and on weekends with advance notice.
6. At no time will the counselor meet individually with a child without being in line of sight of a CYP, DoDEA, LEA, or camp employee or a parent/guardian.
7. The counselor may use only OSD approved materials for trainings, groups, and any other activities.
8. **With the exception of mandatory state, federal, and military reporting requirements (i.e., domestic violence, child abuse, and duty-to-warn situations), as well as oversight review by DoD of the service you received should an adverse or harmful event occur, MFLC support is private and confidential to encourage the greatest level of participation.**

Print Name of Child: _____

Select only one check box below:

☐ **I understand the above CYB-MFLC program description and authorize my child to participate in CYB-MFLC services. This authorization is valid for the duration of my child's enrollment. I understand I can revoke this authorization at any time in writing.**

☐ **I do not authorize my child to participate in CYB-MFLC services.**

PARENT OR GUARDIAN SIGNATURE

DATE



DEPARTMENT OF THE AIR FORCE
HEADQUARTERS 96TH TEST WING (AFMC)
EGLIN AIR FORCE BASE FLORIDA

7 June 2019

MEMORANDUM FOR 96 FSS/FSFC

FROM: 96 FSS/FSYY

SUBJECT: Sibling Discount

1. The sponsor listed below is requesting a sibling discount with School Age Care due to enrollment of a sibling at the Child Development Center.

Sponsor Name: _____

2. In order to receive the discount(s) verification of enrollment of a sibling(s) at the Child Development Center is required.

Sibling Name / Enrollment Date: _____ / _____ CDC/SAC Classroom # _____

Sibling Name / Enrollment Date: _____ / _____ CDC/SAC Classroom# _____

3. Verification from front desk personnel at the Child Development Center that your child is enrolled at is required.

Front Desk personnel Signature / Date _____ / _____

JENNIFER HOFFMANN, DAFC
Airman and Family Program Assistant, 96 FSS/FSYY

CYP INTERVIEW QUESTIONS

Applicant Name: _____

Date: _____

Interviewer Name: _____

1. Tell us about your experiences working with School Age Children.

2. What do you find most rewarding about working with children?

3. What do you find most difficult about working with children?

4. What do feel is important for having successful relationships with your coworkers?

5. Our program is open M-F, 0600-1800. Our staff work split shifts on school days and full shifts on no school days. What is your availability?

6. What talents/skills could you bring to the program?

7. What three words would you use to describe yourself?