

# **Winchester Recreation After School Program**

## **W.R.A.P**

263 Main Street  
Winchester, MA 01890-3311  
Phone: 781-721-7125

## **Vacation Club 2024 - 2025 School Year**

The Recreation Department would like to welcome you to the WRAP Vacation Club for Kindergarten through Grade 2.

Enclosed please find The Winchester Recreation Vacation Club registration packet. In order to prepare for the Vacation Club Program, we ask that all information be submitted by a week prior to the program start date. All information must be fully completed and dated; we will not accept partial packets.

If you have any billing related questions, please call the recreation office at (781) 721-7125. For program related questions, contact WRAP Director, Carol McCollem at [cmccollem@winchester.us](mailto:cmccollem@winchester.us)

Completed documents can be dropped off or mailed to the recreation office. The PDF enrollment forms are also a fillable document. Parents are encouraged to type into the document and save it as your child's name and email them to Michelle Blumsack at [mblumsack@winchester.us](mailto:mblumsack@winchester.us)

**Winchester Recreation After-School Program**  
**263 Main St**  
**Winchester, MA 01890**  
**781-721-7125**  
**Enrollment Form**  
**2024-2025 School Year**

Child's Name: \_\_\_\_\_ Eye Color: \_\_\_\_\_ Skin Color: \_\_\_\_\_  
Home Address: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Height: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Sex: \_\_\_\_\_ Weight: \_\_\_\_\_  
Date of Admission: \_\_\_\_\_ Age at Admission: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
Identifying Marks: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_  
Allergies\*/special diet: \_\_\_\_\_

**If your child has allergies an additional health care form must be filled out and signed by your health care provider**

**PARENT/GUARDIAN INFORMATION:**

Parent/Guardian Name: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Home Telephone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
Work Name: \_\_\_\_\_  
Work Address: \_\_\_\_\_  
Work Phone: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Home Telephone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
Work Name: \_\_\_\_\_  
Work Address: \_\_\_\_\_  
Work Phone: \_\_\_\_\_

# Individual Health Care Plan Form 2024-2025

**(ONLY NEEDS TO BE FILLED OUT IF YOUR CHILD HAS A HEALTH CARE PLAN)**

**Childs Name:** \_\_\_\_\_

*Plan must be renewed annually or when child's condition changes*

Plan was created by: *Place an X on all that apply*

Plan is maintained by: *Check all that apply*

\_\_\_ Parent

\_\_\_ Director

\_\_\_ Doctor or Licensed Practitioner

\_\_\_ Child's Educator

\_\_\_ Program's Health Care Consultant

\_\_\_ Other: \_\_\_\_\_

\_\_\_ Older school age child (9+ years of age)

Description of chronic health care condition: \_\_\_\_\_

Symptoms: \_\_\_\_\_

Medical treatment necessary while at the program: \_\_\_\_\_

Potential side effects of treatment: \_\_\_\_\_

Potential consequences if treatment is not administered: \_\_\_\_\_

Name of educators that received training addressing the medical condition: \_\_\_\_\_

Person who trained the educator (child's health Care practitioner, child's parent, program's Health Care Consultant)

Name of Licensed health Care Practitioner (print name) \_\_\_\_\_ Date \_\_\_\_\_

Licensed Health Care Practitioner consent: \_\_\_\_\_ Date \_\_\_\_\_

Parental/Guardian Consent: \_\_\_\_\_ Date \_\_\_\_\_

## **For Children 9+ years of age**

With written parental consent and authorization of a licensed health care practitioner, this individual Health Plan permits older school age children to carry their own inhaler and /or epinephrine auto-injector an use them as needed without the direct supervision of an educator.

The educator is aware of the contents and requirements of the child's Individual Health Plan specifying how the inhaler or epinephrine auto-injector will be kept secure from access by the other children in the program. Whenever an Individual Health Care Plan provides for a child to carry his or her own medication. The licensee must maintain a back-up supply of the medication for use as needed.

Age of child: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Back-up medication received? Yes \_\_\_ or No \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Administrator's signature: \_\_\_\_\_ Date \_\_\_\_\_

**FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Child's Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Child's Allergies: \_\_\_\_\_

Chronic Health Conditions: Medical, dietary, ADHD, auditory, etc.)

**Emergency Contacts (In order to be contacted)**

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Relationship to child \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Do you give permission for child to be released to this person? Yes \_\_\_\_\_ No \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Relationship to child \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Do you give permission for child to be released to this person? Yes \_\_\_\_\_ No \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Relationship to child \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Do you give permission for child to be released to this person? Yes \_\_\_\_\_ No \_\_\_\_\_

Health Insurance Provider: \_\_\_\_\_ Policy# \_\_\_\_\_

I certify that documentation of physical examination and immunizations in accordance with public school health requirements, and lead poisoning screening in accordance with public health requirements are on file at my child's school. Please initial \_\_\_\_\_

I authorize staff in the child care program who are trained in the basics of first aid/CPR to give my child first aid/CPR when appropriate.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and to secure necessary medical treatment for my child.

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

\_\_\_\_\_  
Date (valid for one year)

## Authorizations/Permissions

**Child's Name:** \_\_\_\_\_

**SUNSCREEN PERMISSION:** We expect that all children will arrive daily with sunscreen already applied. If during the course of the afternoon your child needs to reapply sunscreen they may do so independently. If your child will need assistance from a staff member, we must receive prior authorization to do so. You must send your child in with sunscreen labeled with their name on it.

\_\_\_\_\_ I hereby authorize The Winchester Recreation Staff to reapply sunscreen on my child as needed.

\_\_\_\_\_ I **do not** authorize The Winchester Recreation to apply sunscreen on my child.

### SLEDDING PERMISSION

\_\_\_\_\_ I give permission for my child to go to sledding during the winter months while he/she attends The Winchester Recreation After-School Program.

\_\_\_\_\_ I **do not** authorize my child to go to sledding during the winter months while he/she attends The Winchester Recreation After-School Program.

### Sledding Waiver of Liability Statement

I, the parent or legal guardian of the child listed below, release The Winchester Recreation Department, from any and all claims resulting from injury or damage that may be sustained by my child while participating in sledding.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### OFF SITE ACTIVITIES

I give permission for my child to participate in all of the regularly scheduled on-going activities located at the following off site facilities. **Please mark with a check.**

\_\_\_\_\_ Ginn Field      \_\_\_\_\_ Lincoln School Park      \_\_\_\_\_ Neighborhood Surrounding Mystic School  
\_\_\_\_\_ Grounds of McCall Middle School      \_\_\_\_\_ Winchester Public Library

**MEDIA RELEASE INFORMATION:** Student photographs may be used in newsletters or publications, Rec. Facebook Page and Winchester Recreation brochures.

**Please check.**

\_\_\_\_\_ I hereby consent and authorize The Winchester Recreation afterschool program to use photographs produced of my child for publicity purposes.

\_\_\_\_\_ I do not consent and authorize my child being included in any photographs of my child.

### TOOTH BRUSHING AUTHORIZATION/WAIVER

\_\_\_\_\_ I do not wish for my child to participate in tooth brushing while here at W.R.A.P.

\_\_\_\_\_ I wish to have my child participate in tooth brushing. I am responsible for providing my child's toothbrush and toothpaste labeled with their name on it and will be replaced every 3 months.

{606 CMR 7. 11 (11) (d)}.

**ALCOHOL-BASED HAND SANITIZER:** If soap and water are not available, alcohol-based hand sanitizers (with at least 60% alcohol) are an effective alternative for cleaning hands and are recommended as an alternative to soap and water by the Centers for Disease Control and Prevention (CDC) and Massachusetts Department of Public Health (MDPH).

\_\_\_\_\_ I give permission for my child to use hand sanitizer in after-school.

\_\_\_\_\_ I do not give permission for my child to use hand sanitizer in after-school

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## Transportation Plan and Authorization

Childs Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

My Child is registered for the following days:

	Tuesday	Wednesday	Thursday	Friday
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

My Child will arrive at the program by:

	Parent/Authorized Drop off	Unsupervised walk	Supervised walk (indicate by whom)
	<input type="checkbox"/>	<input type="checkbox"/>	

My Child will depart the program by:

	Parent/Authorized pick up	Unsupervised walk* <small>(Must be 9 or older)</small>	Supervised walk (indicate by whom)
	<input type="checkbox"/>	<input type="checkbox"/>	

\* Complete "Consent for Child to Leave the School Age Child Care Program" form per CMR 7.04(7)(a)8

I give permission for my child to be released from the program at the end of the day as stated above and/or I give my permission to release my child to the following people.

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Relationship to child \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Relationship to child \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Relationship to child \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**THIS PERMISSION IS VALID FOR ONE PROGRAM YEAR FROM THE DATE OF SIGNATURE. ANY OTHER TRANSPORTATION REQUESTS MUST BE STATED IN WRITING.**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CONSENT FOR CHILDREN 9 YEARS AND OLDER FOR LEAVING THE PROGRAM**

**Child MUST be 9 years old or older**

This form is to be used if the child has permission to walk home at the end of the program day or any time a child has permission to leave the program to attend enrichment programs separate from the childcare program.

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

Address: \_\_\_\_\_

\_\_\_\_\_

I, \_\_\_\_\_ authorize my child, \_\_\_\_\_

(Parent/Guardian's Name)

(Child's name)

to leave the program. This permission is in effect from \_\_\_\_\_ to \_\_\_\_\_.

Date

Date

Activity/Location: \_\_\_\_\_

Method of Transportation: \_\_\_\_\_

Leave Time: \_\_\_\_\_ Return Time: \_\_\_\_\_

Restrictions: \_\_\_\_\_

Activity/Location: \_\_\_\_\_

Method of Transportation: \_\_\_\_\_

Leave Time: \_\_\_\_\_ Return Time: \_\_\_\_\_

Restrictions: \_\_\_\_\_

Activity/Location: \_\_\_\_\_

Method of Transportation: \_\_\_\_\_

Leave Time: \_\_\_\_\_ Return Time: \_\_\_\_\_

Restrictions: \_\_\_\_\_

Activity/Location: \_\_\_\_\_

Method of Transportation: \_\_\_\_\_

Leave Time: \_\_\_\_\_ Return Time: \_\_\_\_\_

Restrictions: \_\_\_\_\_

Activity/Location: \_\_\_\_\_

Method of Transportation: \_\_\_\_\_

Leave Time: \_\_\_\_\_ Return Time: \_\_\_\_\_

Restrictions: \_\_\_\_\_

I understand that the program has the right to rescind the above privilege if my child's behavior warrants the limitation.

I recognize that my child will not be supervised by staff while s/he is away from the program.

I understand I am responsible for my child once s/he leaves the program.

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Program Staff Signature)

\_\_\_\_\_  
(Date)