Boston Centers for Youth & Families
Martin J. Walsh, Mayor
Christopher Byner, Interim Executive Director

JAMCC

Jackson Mann Community Center After-School Program
500 Cambridge St, Allston MA 02134

Enrollment checklist

Name of Child

- ☐ **Session enrollment form signed**
- ☐ **Deposit**
- ☐ **Completed intake package**
  - **Enrollment form**
  - **First aid/ emergency medical consent form**
  - **Consent to leave the program (age 9 or older only!)**
  - **Child contract for leaving program (ages 9 or older only!)**
  - **Transportation plan and authorization**
  - **Medication consent form (if needed)**
  - **Individual health care plan (if needed)**
  - **Sun block/ insect repellent permission**
  - **Tooth brushing permission**
  - **CDBG form completed**
  - **Membership form (marked sections completed)**
- ☐ **Signed fee agreement**
- ☐ **Additional documents**
  - **Parent I.D**
  - **Child photo**
  - **Birth certificate all children**
  - **Physical/ immunizations**
  - **Proof of address (two from current month, examples: utility bills, lease, DMV registration, sorry, no cell phone bills)**
  - **Custody agreements (if necessary)**
  - **CDBG**

Name of child:

Name of Parent/ Guardian:

SESSION ENROLLMENT

(Please check boxes for all sessions you wish to enroll your child)

- ☐ Session 1: Weeks of July 3rd-July 7th and July 10th-14th
- ☐ Session 2: Weeks of July 17th-21st and July 24th-28th
- ☐ Session 3: Weeks of July 31st-August 4th and August 7th-11th
- ☐ Session 4: Weeks of August 14th-18th and August 21st-25th

REQUIRED DOCUMENTS

- ☐ **Parent I.D.**
- ☐ **Child photo**
- ☐ **Birth certificate (all children in family)**
- ☐ **Physical/ immunizations**
- ☐ **Intake package**
- ☐ **Proof of address (utility, lease, no cell phone bill accepted)**
- ☐ **Medication administration documentation (if required)**
- ☐ **Deposit and one week initial payment received**

Will your child attend summer school? If so, Where?

PROGRAM POLICIES AND PROCEDURES

Payment Policy

This fee is per session (2 weeks) selected: part time slots available for $38/day

***One week sessions are available upon request with tuition of $190.00 per child (sibling discounts applied).**

Name of child:

Name of Parent/ Guardian:

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(Please check boxes for all sessions you wish to enroll your child)

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JAMCC

Jackson Mann Community Center After-School Program
500 Cambridge St, Allston MA 02134

JMCC OFFICE USE ONLY:
Original start date: _____
Age of child at admission: _____
Termination date: _____

Participant Information

Child's First Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____

Age at Admission: _____ Date at Admission: _____

Daytime Phone: (_____)_____-_____ Evening Phone: (_____)_____-_____

Cell Phone: (_____)_____-_____

Gender

☐ Male ☐ Female

Race/Ethnicity

☐ Asian
☐ Black or African American
☐ Hispanic
☐ Multiracial
☐ Caucasian/White
☐ Other *(please specify)*:_____

Primary Language Spoken at Home

☐ Chinese ☐ French Creole ☐ Portuguese Creole ☐ Polish
☐ English ☐ Italian ☐ Somali ☐ Filipino
☐ Spanish ☐ French ☐ Portuguese ☐ Vietnamese
☐ Other *(please specify)*:_____

Education year of child:

☐ Grade K2 ☐ Grade 3
☐ Grade 1 ☐ Grade 4
☐ Grade 2 ☐ Grade 5
☐ Grade 6* ☐ Grade 7*

***Any child with a documented disability may stay within the program until they are 16 years of age. Please discuss with the program director.**

Parent/Guardian Information
Parent One

Parent/Guardian Name: _____ Relationship to Child: _____

Home Phone Number: (____)_____-_____ Work Phone Number: (____)_____-_____

Cell/Mobile Phone Number: (____)_____-_____ Pager Number: (____)_____-_____

Business Name: _____

Address: _____ City: _____ Zip: _____ State: _____

Business Fax: (____)_____-_____ Work Days/Hours: _____

Internet Access ☐Yes ☐No Email Address: _____

Parent Two

Parent/Guardian Name: _____ Relationship to Child: _____

Home Phone Number: (____)_____-_____ Work Phone Number: (____)_____-_____

Cell/Mobile Phone Number: (____)_____-_____ Pager Number: (____)_____-_____

Business Name: _____

Address: _____ City: _____ Zip: _____ State: _____

Business Fax: (____)_____-_____ Work Days/Hours: _____

Emergency Contact Information
*Your child may be released to persons listed as emergency contacts.

1st EMERGENCY CONTACT: _____ Relationship to Child: _____

Home Phone Number: (____)_____-_____ Work Telephone (____)_____-_____

Cell Phone Number: (____)_____-_____

Can your child be released to this person? ☐ **Yes** ☐ **No**

2nd EMERGENCY CONTACT: _____ Relationship to Child: _____

Home Phone Number: (____)_____-_____ Work Telephone Number (____)_____-_____

Cell Phone Number: (____)_____-_____
Can your child be released to this person? ☐ **Yes** ☐ **No**

Transportation: Arrival to the Program:
Please accompany your child into the building. There will be a staff member in the main entrance lobby. Please check in with the staff member because they may have important notices and information to share with you. Your child may then walk to the cafeteria and check in and greet staff members there. If your child is 5 years of age -8 years of age, we are asking that your walk your child to the cafeteria.

Transportation: Departure from Program:
How will your child depart from the program at the end of the day?
❑ My child will be picked up by the following person(s) not listed as parents or emergency contacts

_____ _____
Name Relationship to Child

_____ _____
Name Relationship to Child

_____ _____
Name Relationship to Child

_____ _____
Name Relationship to Child

*Your child will not be released to any person(s) not included on this list. ANY OTHER TRANSPORTATION REQUESTS MUST BE STATED IN WRITING AND MAINTAINED IN THE CHILD'S FILE OR THE ABOVE PLAN MUST BE IMPLEMENTED. THIS PERMISSION IS VALID FOR ONE PROGRAM YEAR FROM THE DATE OF SIGNATURE.
*If your child will be picked up, the person picking him/her up must be on time. If your child is late being picked up you will be charged a late fee of $1.00 per minute, due the next business day.

Medical Information
Does your child have allergies and/or medical conditions? (Medication, food, latex, bee stings, etc.)
☐ Yes ☐ No. If yes, please:
_____

Date of last doctor's visit: _____ Was this a routine physical or special visit?

Please explain _____
Does your child receive counseling or early intervention services? ☐ Yes ☐ No
Would you like us to be in contact with the counselor? ☐ Yes ☐ No
If yes, please give the counselors name and phone number _____

If your child has an IEP please make sure a copy of it is attached to the application.

List any special limitations or concerns your child may have including dietary restrictions, allergies, chronic health conditions (i.e. asthma); if none, please indicate by writing "none": _____

Physical Profile and Special Interest Form

Child's Name:_____ Birth Date: ____/____/____
Sex: _____Eye Color: _____ Hair Color: _____
Height:_____Weight: _____Skin Color: _____
Identifying marks (moles. Scars, birthmarks etc.):

_____
_____
_____

Child's Housing Status

☐ Living with family ☐ Living with foster family ☐ Homeless, in shelter
☐ Living with friends ☐ Homeless, no shelter ☐ Other *(please specify):*_____

Number of children 18 years or younger living in household: _____

Family Life

Are there any major events or changes in the child's life currently or in recent past that might affect his/her behavior (i.e. new job, new sibling, parental separation or divorce, illness, death, moving, etc.)? _____
_____
_____
_____

What are your worries about how your child will adjust to the summer program? _____
_____
_____

What do you expect your child to gain from his/her experience in the summer program? _____
_____
_____

Is there anything else you would like us to know about your child? _____
_____
_____

Eating

Is you child usually hungry at mealtime? ❑ Yes ❑ No

What are your child's favorite foods? _____

Any eating problems, food allergies, or special eating habits? _____
_____

Are there any foods you do not want your child to eat for religious, personal or medical reasons? ___
_____
_____

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM

Child's Name: _____ Date of Birth: _____

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/or to _____, and to secure necessary medical treatment for my child.

Child's Physician Name: _____
Address: _____
Phone Number: _____

Child's Allergies: _____
Chronic Health Conditions: _____

Emergency Contacts (*In order to be contacted*)
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 Coverage_____ Policy #_____

Parent/Guardian Name: _____ Phone_____ Cell_____

Parent/Guardian Name: _____ Phone_____ Cell_____

_____ _____
Parent /Guardian Signature Date (valid for one year)

Department of
Early Education and Care
THE COMMONWEALTH OF MASSACHUSETTS

Small Group, Large Group and School Age Child Care Licensing

POLICY STATEMENT: Individual health care plans

All programs must maintain as part of a child's record, an Individual Health Care Plan (IHCP) for each child with a chronic medical condition which has been diagnosed by a licensed health care provider as required by 606 CMR 7.11 (3)(a)-(c). An IHCP ensures that a child with a chronic medical condition receives health care services he/she may need while attending the program.

Programs must develop an IHCP and collaboration with a parent/guardian signature, school age child who is 9 years of older (when appropriate), program educators and the child's license health care practitioner, who must authorize the IHCP.

The IHCP must include the following:

- Description of the chronic condition which has been diagnosed by a licensed health care practitioner.
- Description of the symptoms of the condition
- Outline of any medical treatment that may be necessary while the child is in care
- Description of the potential side effects of the treatment
- Outline of the potential consequences to the child's health if the treatment is not administered.

An educator must have successfully completed training relative to a child's ICHP. This training must be given by the child's health care practitioner or, with a child's health care practitioner's written consent, by the child's parent or the program's health care consultant. The training must specifically address the child's medical condition, medication and other treatment needs. Some examples of an IHCP would include children with asthmatic conditions, allergic reactions, ADHD or diabetic conditions. IHCP's are not required for children without chronic conditions needing oral or topical medications.

In the event of *an unanticipated,* non-life-threatening condition requiring treatment (as specified in the IHCP) the educator must make a reasonable attempt to contact the parent/guardian prior to administrating the unanticipated medication or beginning the unanticipated treatment. If parents/guardians cannot be reached immediately, they should be notified as soon as possible after the medication or treatment has been administered to the child.

Educators must ensure that they document the administration of all medications and medical treatments and the child's medication/treatment log.

Child's Photo

Parent/Guardian Signature: _____ Date: _____

Individual Health Care Plan Form

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

Check all that apply...

Plan was created by:

- ___ Parent
- ___ Doctor or Licensed Practitioner
- ___ Program's Health Care Consultant
- ___ Older school age child (9+ years of age)
- ___ Other: _____

Plan is maintained by:

- ___ Director
- ___ Assistant Director
- ___ Child's educator
- ___ Other: _____

Name of Child: Date:
Any change to the child's health care plan? YES (indicate changes below) NO (updated physician/parental signature required)
Name of chronic health care condition
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 (Please Print)_____

Licensed Health Care Practitioner authorization:_____ Date:_____

Parent/Guardian Consent: _____ Date _____

For Older Children ONLY (9+ years of age)

With written parental consent and authorization of a licensed health care practitioner, this individual Health Care Plan permits older school age children to carry their own inhaler and/or epinephrine auto-injector and 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 Care Plan specifying how the inhaler or epinephrine auto-injector will be kept secure by access of 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 on-site a back-up supply of the medication for use as needed

Age of Child:_____ Date of Birth: _____ Back-up Medication received? YES NO

Parent Signature _____ Date: _____

Administrator's Signature_____ Date:_____

Parent/Guardian Signature: _____ Date: _____

Commonwealth of Massachusetts

Department of Early Education and Care

MEDICATION CONSENT FORM 606 CMR7.11(2)(b)

Name of Child: _____

Name of Medication: _____

Please ☑ one of the following: Prescriptions: Oral/Non-Prescription

Unanticipated Non-Prescription for mild symptoms

Topical Non- Prescription (applied to open wound/ broken skin)

My child previously taken this medication

My child has not previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her with his individual health care plan

Dosage: _____

Date(s) Medication to be given: _____

Reasons for Medication: _____

Possible Side-effects: _____

Direction for Storage: _____

Name and Phone Number of the prescribing health care practitioner:

_____

Child's Health Care Practitioner Signature: _____ Date: _____

I _____ (parent/ guardian) gives permission to authorize educator(s) to administer medication to my child as indicated above.

Parent/Guardian Signature: _____ Date: _____

For topical, non-prescription NOT applied to open wound/ broken skin (parent signature only)

Parent/Guardian Signature: _____ Date: _____

OFFICE OF JOBS AND COMMUNITY SERVICES / EDIC

A Division of BOSTON REDEVELOPMENT AUTHORITY

CDBG FY

BENEFICIARY INCOME VERIFICATION FORM

DATE	LAST NAME (child)	FIRST NAME	Middle Initial	GENDER ☐ MALE ☐ FEMALE
ADDRESS *		CITY		ZIP CODE
TELEPHONE NUMBER		DATE OF BIRTH (child)		I.D. NUMBER *(If applicable)*

NEIGHBORHOODS *(Check zip code you live in)*

- ☐ ALLSTON/BRIGHTON - *02134, 02135, 02146*
- ☐ CHARLESTOWN - *02129*
- ☐ CHINATOWN / DOWNTOWN - *02109, 02110, 02111, 02114*
- ☐ EAST BOSTON - *02128*
- ☐ FENWAY - *02115, 02215*
- ☐ HYDE PARK - *02136*
- ☐ JAMAICA PLAIN - *02130*
- ☐ MATTAPAN - *02126*
- ☐ NORTH or SOUTH DORCHESTER - *02122, 02124, 02125*
- ☐ NORTH END - *02113*
- ☐ ROSLINDALE - *02131*
- ☐ ROXBURY - *02119, 02120, 02121*
- ☐ SOUTH BOSTON - *02127*
- ☐ SOUTH END / BACKBAY - *02118, 02108, 02116*
- ☐ WEST ROXBURY - *02132, 02167*

RACE/ETHNICITY/ MULTI-RACE

- ☐ WHITE (Non-Latino)
- ☐ BLACK (Non- Latino)
- ☐ HISPANIC
- ☐ AMER. INDIAN / ALASK. NATIVE
- ☐ ASIAN
- ☐ HAITIAN
- ☐ CAPE VERDEAN
- ☐ OTHER: _____
- ☐ HAWAIIAN/PACIFIC ISLANDER
- ☐ AFRICAN AMER & WHITE
- ☐ ASIAN & WHITE
- ☐ AMER. INDIAN & WHITE
- ☐ AMER. INDIAN/ALASKAN & WHITE
- ☐ AMER. INDIAN/ALASKAN & BLACK

PARTICIPANT CHARACTERISTICS
(Check off all that apply)

- ☐ TAFDC RECIPIENT
- ☐ VETERAN STATUS
- ☐ DISABLED
- ☐ REFUGEE/ENTRANT
- ☐ FEMALE-HEADED HOUSEHOLD
- ☐ BHA RESIDENT

Mark the HOUSEHOLD SIZE box and select ONE of the three income options going across ON THE SAME LINE.
*Example: a **3-person** household with an annual income of **$17,000** would be marked on the third row, as **Very Low Income.***

☒ *3 Persons* HOUSEHOLD SIZE *(Including You)*	☒ *0 to $25,450* ***Very Low Income*** *(30% of Median)*	☐ *$25,451 to $42,350* ***Low Income***	☐ *$42,351 to $61,000* ***Low-Moderate Income***
☐ *1 Person*	☐ *0 to $19,800*	☐ *$19,801 to $32,950*	☐ *$32,951 to $47,450*
☐ *2 Persons*	☐ *0 to $22,600*	☐ *$22,601 to $37,650*	☐ *$37,651 to $54,200*
☐ *3 Persons*	☐ *0 to $25,450*	☐ *$25,451 to $42,350*	☐ *$42,351 to $61,000*
☐ *4 Persons*	☐ *0 to $28,250*	☐ *$28,251 to $47,050*	☐ *$47,051 to $67,750*
☐ *5 Persons*	☐ *0 to $30,550*	☐ *$30,551 to $50,850*	☐ *$50,851 to $73,200*
☐ *6 Persons*	☐ *0 to $32,800*	☐ *$32,801 to $54,600*	☐ *$54,601 to $78,600*
☐ *7 Persons*	☐ *0 to $35,050*	☐ *$35,051 to $58,350*	☐ *$58,351 to $84,050*
☐ *8 Persons or more*	☐ *0 to $37,300*	☐ *$37,301 to $62,150*	☐ *$62,151 to $89,450*

Mark the source(s) of Income Documentation:

- ☐ TAFDC
- ☐ SSI/SSDI
- ☐ FOOD STAMP
- ☐ REFUGEE ASSISTANCE
- ☐ BPS SCHOOL DATA
- ☐ CHILD SUPPORT
- ☐ ALIMONY
- ☐ SECTION 8
- ☐ UNEMPLOYMENT INS.
- ☐ PAYCHECK / W-2
- ☐ PUBLIC HOUSING: _____ (name of development)
- ☐ OTHER: _____

I hereby confirm that the information that I have provided on this form is true and accurate to the best of my knowledge.

APPLICANT'S SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN SIGNATURE *(If Applicable)*: _____ DATE: _____

PROGRAM INTERVIEWER SIGNATURE: _____ DATE: _____

**Information collected in this form is confidential and only used to verify that CDBG funds benefit eligible Boston residents.*

OFICINA DE EMPLEOS Y SERVICIOS A LA COMUNIDAD *(JCS por sus siglas en inglés)*

Una División de la AUTORIDAD DE REURBANIZACIÓN DE BOSTON (BRA)

CDBG FY

VERIFICACIÓN DE INGRESOS DE BENEFICIARIOS DEL PROGRAMA

FECHA	APELLIDO (el nino)	NOMBRE	INICIAL	GENERO ☐ MASCULINO ☐ FEMENINO
DIRECCION *		CIUDAD		CODIGO POSTAL
NUMERO DE TELEFONO		FECHA DE NACIMIENTO (el nino)		NÚMERO IDENTIFICACION *(si la identidad es confidencial)*

VECINDARIOS *(Seleccione el vecindario donde reside)*

- ☐ ALLSTON/BRIGHTON - *02134, 02135, 02146*
- ☐ CHARLESTOWN - *02129*
- ☐ CHINATOWN / DOWNTOWN - *02109, 02110, 02111, 02114*
- ☐ EAST BOSTON - *02128*
- ☐ FENWAY - *02115, 02215*
- ☐ HYDE PARK - *02136*
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- ☐ ROXBURY - *02119, 02120, 02121*
- ☐ SOUTH BOSTON - *02127*
- ☐ SOUTH END / BACKBAY - *02118, 02108, 02116*
- ☐ WEST ROXBURY - *02132, 02167*

RAZA/ETNIA/ MULTIRACIAL

- ☐ BLANCA (No-Latina)
- ☐ NEGRA (No- Latina)
- ☐ HISPANA
- ☐ ASIÁTICA
- ☐ HAITIANA
- ☐ CABOVERDEANA
- ☐ HAWAIANA-ISLA DEL PACIFICO
- ☐ AFRO-AMERICANA-BLANCA
- ☐ ASIATICA-BLANCA
- ☐ INDIGENA AMER-BLANCA
- ☐ INDÍGENA AMER. / NATIVO DE ALASKA
- ☐ INDIGENA AMER/ALASKA-BLANCA
- ☐ INDIGENA AMER/ALASKA-NEGRA
- ☐ OTRA: _____

CARACTERÍSTICAS DEL PARTICIPANTE *(Marque todas las que apliquen)*

- ☐ RECIBE AYUDA TRANSITORIA PARA FAMILIAS CON HIJOS DEPENDIENTES (TAFDC)
- ☐ VETERANO/A
- ☐ DISCAPACITADO/A
- ☐ REFUGIADO/A
- ☐ MUJER, CABEZA DE HOGAR
- ☐ RESIDENTE DE BHA

Indique el NUMERO DE PERSONAS que reside en el hogar y el nivel de ingresos correspondiente, en esa MISMA LINEA.
*Ejemplo: una familia de **3-personas** con ingreso anual de **$17,000** se indica en la tercera línea, como ingreso muy bajo.*

☒ *3 Personas*	☒ *0 a $25,450*	☐ *$25,451 a $42,350*	☐ *$42,351 a $61,000*
# DE PERSONAS EN EL HOGAR *(Inclúyase Usted)*	***Ingreso muy bajo*** *(Very Low Income)*	***Ingreso bajo*** *(Low-Income)*	***Ingreso bajo-moderado*** *(Low-Moderate Income)*
☐ *1 Persona*	☐ *0 a $19,800*	☐ *$19,801 a $32,950*	☐ *$32,951 a $47,450*
☐ *2 Personas*	☐ *0 a $22,600*	☐ *$22,601 a $37,650*	☐ *$37,651 a $54,200*
☐ *3 Personas*	☐ *0 a $25,450*	☐ *$25,451 a $42,350*	☐ *$42,351 a $61,000*
☐ *4 Personas*	☐ *0 a $28,250*	☐ *$28,251 a $47,050*	☐ *$47,051 a $67,750*
☐ *5 Personas*	☐ *0 a $30,550*	☐ *$30,551 a $50,850*	☐ *$50,851 a $73,200*
☐ *6 Personas*	☐ *0 a $32,800*	☐ *$32,801 a $54,600*	☐ *$54,601 a $78,600*
☐ *7 Personas*	☐ *0 a $35,050*	☐ *$35,051 a $58,350*	☐ *$58,351 a $84,050*
☐ *8 Personas o mas*	☐ *0 a $37,300*	☐ *$37,301 a $62,150*	☐ *$62,151 a $89,450*

Indique la documentación que verifica el nivel de ingreso:

- ☐ TAFDC
- ☐ SSI/SSDI
- ☐ VALES CANJEABLES POR ALIMENTO
- ☐ AYUDA DE REFUGIADO
- ☐ INFORMACION DE LA POBLACION ESCOLAR
- ☐ MANUTENCIÓN INFANTIL
- ☐ PENSIÓN ALIMENTICIA
- ☐ AYUDA GENERAL
- ☐ SEGURO DE DESEMPLEO
- ☐ EMPLEO / W-2
- ☐ VIVIENDA PUBLICA: _____ (nombre del conjunto)
- ☐ OTRO: _____

A través de la presente confirmo que la información que aquí suministro es verdadera y exacta a mi real saber y entender.

FIRMA DEL/A PARTICIPANTE: _____ FECHA: _____

FIRMA DEL PADRE/MADRE/GUARDIÁN (*Si aplica*): _____ FECHA: _____

FIRMA DEL/A ENTREVISTADOR/A: _____ FECHA: _____

**Esta información es confidencial y se usará sólo para verificar que el fondo CDBG beneficia a residentes elegibles de Boston.*

FEE COLLECTION POLICY

- All fee agreements must be in writing, signed and dated by the Program Director and client.
- Payments are due by Friday of every week unless alternate arrangements are made with director.
- Payments must be made by check or money order. Money orders may be required if checks bounce.
- Monthly invoices are printed by the Bookkeeper, given to Administration for review and given to clients.
- The Administration shall write letters to all clients who are 14 days overdue; these clients are given seven days in which to respond.
- Notice of termination shall be given by Administration if there is no response at the end of 7 days. The Director shall be notified.
- Administration shall be notified by the Bookkeeper of any payments made on overdue accounts.
- Termination shall be effected if no payments are received in 14 days. The Director shall be notified.
- Requests for payback schedules must be arranged with Administration.
- If payback schedules are not followed, a termination notice shall be sent and the account shall be given to the collection agency.

First week's tuition and an initial deposit of one week's tuition is paid upon enrollment. This deposit is applied toward the last week of tuition if a two-week notice is given. Failure to give a two-week notice shall result in loss of deposit. Deposits are non-refundable under any circumstances.

Tuition fees continue to accrue during suspension or until formal termination is executed by either the Administration or client. Formal termination is required in writing.

I understand and agree to the policies stated above: _____ **Date**_____

CIRCLE ONE: INTAKE / TERMINATION / CHANGE

PARENT NAME _____

PARENT SS# _____

ADDRESS _____ **CITY**_____ **ZIP**_____

TELEPHONE **HOME** _____ **WORK** _____

CHILD NAME _____

---------- **OFFICE USE ONLY** ----------

PROGRAM _____

START/TERM DATE _____

SLOT TYPE _____

DAILY FEE _____

DEPOSIT _____

CC: PARENT, DIRECTOR, BOOKEEPER

Media/Publicity Release

I/we authorize Boston Center for Youth and Families/Jackson Mann Community Center, and their successors to use any recordings in any media (through exhibition, distribution, reproduction, publication or otherwise) that may include my child's name, likeness, image, voice, and performance. The BCYF/Jackson Mann Community School & Council, Inc. School & Council, Inc. shall own the entire right, title and interest at any time existing in such recordings as they desire and may use the recordings or excerpts in such recordings in any way. The BCYF/Jackson Mann Community School & Council, Inc. shall own the entire right, title and interest at any time existing in such recordings, including without limitation, all rights under copyright law. The BCYF/Jackson Mann Community School & Council, Inc. may use my child's name, likeness, image, voice or performance to promote the program and for related purposes of advertising or trade. My child and I waive all rights under privacy, publicity, defamation, and proprietary rights relating to the recordings. The Jackson Mann Community Center School-Age Program may transfer or license any of its rights hereunder.

I/we acknowledge that I have the right to enter into this Release on the behalf of my child. I and my child release, indemnify, and hold that the Jackson Mann Community Center School-Age Program, their licensees, successors, and assignees harmless against all claims, liabilities, and expenses arising out of the breach of any of my representations or promise.

I/we hereby waive any right that I may have to inspect and/or approve the finished product or press release that may be used in connection with the photographs, films, or likeness.

I have read and understand the terms and conditions of this Release Form.

Parent/Guardian Signature: _____ Date: _____

Family/ Adult Only

Membership Application

The Mission of Boston Centers for Youth & Families is to enhance the quality of life for Boston residents by partnering with community center councils, agencies, and businesses to support children, youth, individuals and families through a wide range of comprehensive programs and services according to neighborhood needs.

Head of Household information (Parent/ Guardian) – Member 1

First Name: _____ Last Name: _____ ☐ Female ☐ Male

Home Address: _____
Street Apt. City/Neighborhood Zip Code

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Date of Birth: _____

Ethnicity (select all that apply): ☐ Asian ☐ Black ☐ Native American

☐ Native Hawaiian ☐ White

Are you of Hispanic or Latino origin? ☐ Yes ☐ No

Parent/Guardian Signature: _____ Date: _____