Oxford Public Schools
Edu-Care Summer Program Registration Form

(THIS PROGRAM COMPLIES WITH MASS DPH-105CMR430.190 SEC.C)

The Oxford School District does not discriminate on the basis of race, color, sex, religion, national origin, sexual orientation, gender identity, disability or homelessness.

Once again, the Oxford Public Schools will be offering the Edu-Care Summer Program to **students in grades K through 6**. To register your child(ren) for this program, please complete the form below (one for each child attending) along with the following:

1. Edu-Care Summer Program - Child Health Information Form
2. Authorization to Administer Medication to Child Form
3. Parental Consent, Release from Liability and Indemnity Agreement

Send complete applications to:

Oxford Public Schools
4 Maple Road, 2nd Floor
Oxford, MA 01540

All forms must be completed and returned or your child will not be allowed to attend.
DAYCARE ACCOUNTS MUST BE PAID IN FULL BEFORE REGISTRATION

Payments must be made in advance or attendance will not be permitted. Please stay current with payments to avoid a late fee .

Wednesday is Field Trip Day - children must attend at least one additional day in that week to be eligible to attend the Field Trip.

Summer Program Information

Place: Chaffee Elementary School
9 Clover St. – Oxford, MA

Time: 7:00 AM to 5:30 PM

Cost: $30 per day (children must bring lunch)

Payment Information

Make Check payable to: Town of Oxford School Department

Mail to: 4 Maple Rd., 2nd Floor
Oxford, MA 01540
Attention: Edu-Care

Child's Name: ___________________________ Grade last completed:___ School: ________________________

Parent/Guardian Name: ___________________________ Address: ______________________________________

Home Phone: ____________________ Work Phone: ___________________ Cell Phone: ___________________

Other persons authorized to pick-up your child: ____
____

A valid photo ID will be required at time of pick-up.

T-SHIRT SIZE: Child: (S) (M) (L)
(Circle One) Adult: (S) (M) (XL)

Please circle the days for which you would like to register your child.

You will be charged for all days registered.

June

M	T	W	T	F
25	26	27	28	29

July

M	T	W	T	F
2	3	4	5	6
9	10	11	12	13
16	17	18	19	20
23	24	25	26	27
30	31			

August

M	T	W	T	F
		1	2	3
6	7	8	9	10
13	14	15	16	17

Parent/Guardian Signature: ___________________________________ Date: __________

Edu-Care Summer Program - Child Health Information Form

Dear Parents,

In order for us to have updated information on file in case of illness or injury that requires medical attention, kindly fill out **BOTH** pages of this form complete and return it with your application for the Edu-Care Summer Program.

Student's Name: ____ Phone Number: __________________

Address: ____

Please indicate the person to call FIRST in case of injury or illness

Father's Name: ____

Address (If different from above): ____

Place of Employment: ____________________________________ Phone Number: __________________

Mother's Name: ____

Address (If different from above): ____

Place of Employment: ____________________________________ Phone Number: __________________

If both parents are away from home and it is necessary to send your child home from the program, who will be responsible for your child and where may these persons be reached? The Oxford School Department is not responsible for providing transportation when a child must be sent home because of illness or injury. Therefore: *Either the parent or the persons named below must assume this responsibility*.

Responsible persons to be called in case of illness when parents cannot be reached

Name: ____ Phone Number: __________________

Name: ____ Phone Number: __________________

Name: ____ Phone Number: __________________

Per Massachusetts Law, the Oxford School Department is not legally or financially liable for medical treatment (other than normal first aid) for a child who is injured or who becomes seriously ill while at school. If your child should be injured or become suddenly ill and requires immediate medical attention beyond the usual first aid measures and if we are unable to contact you personally, or any of the person named above, do you authorize School Department personnel to make the best possible arrangement available for the welfare of your child?

YES: __________ or NO: __________

If you answered NO to this question, please indicate clearly your desires which are to be followed in any emergency.

____

____

____

Student's Physician: ______________________________________ Phone Number: __________________

Address: ____

Health Insurance: ____

In case of emergency, your child will be transported to UMASS Memorial Medical Center, unless otherwise indicated below.

____

If your child is on daily medication, please indicate below and fill out the AUTHORIZATION TO ADMINISTER MEDICATION TO A CHILD form. This form must be completed before registration is accepted.

____

____

____

Children are required to have the following immunizations before attending camp. Please check with your child's **physician and/or school nurse and get a copy of updated immunization records**.

*** REQUIRED IMMUNIZATIONS *** Children and staff under 18 years old		
IMMUNIZATIONS	**DOSE(S)**	**X/√**
MMR	1	
Measles	2nd Dose Required	
Polio (OPV or e-IPV)	3 4 Doses required if mixed schedule vaccine give (IPV and OPV)	
Diphtheria and Tetanus Toxoids Pertussis	4 DtaP/DTP/DT/Td	
BOOSTER DOSE OF TETANUS/DIPHTHERIA, (td) REQUIRED IF GREATER THAN 10 YEARS SINCE LAST DOSE.		
Hepatitis B: (for children born after 1/92)	3 (effective 1-1-99)	

COPY OF IMMUNIZATIONS MUST BE SUPPLIED

List any known allergies: ____

List any condition(s) or impairments that may affect child's activities while at the program: ____________

____

Children are required to have a physical examination conducted during the preceding 24 months. Indicate month and year of most recent physical examination.

Month: ___________________________ Year: __________________

If any of the information contained on this form changes during the summer, please notify the staff in writing of these changes.

Parent/Guardian Signature: ___________________________________ Date: ______________________

Relationship: ____

OXFORD PUBLIC SCHOOLS
OXFORD, MASSACHUSETTS

PARENTAL CONSENT, RELEASE FROM LIABILITY AND INDEMNITY AGREEMENT

I/We, the undersigned father, mother or guardian (circle or insert legal relationship to student, e.g., "parent" guardian) of ____________________________________(insert name of student) ("my child"), a minor, do hereby consent to my child's participation in voluntary athletic or recreation programs of the Town, City and/or Public Schools of Oxford (hereinafter "the Town/City").

I/We also agree to forever RELEASE the Town/City, a municipal corporation of the Commonwealth of Massachusetts, and/or the Public Schools of Oxford, the School Committee, and all their employees, officers, agents, board members, volunteers and any and all individuals and organizations assisting or participating in voluntary athletic or recreation programs of the Town/City or Public Schools ("the Releases") from any and all claims, actions, rights of action, damages, costs, loss of services, expenses, compensation and attorneys' fees that may have arisen in the past, or may arise in the future, directly or indirectly, from known and unknown personal injuries to my child or property damage resulting from my child's participation in the said Town/City and/or Public School's voluntary athletic or recreation programs which I/We may now or hereafter have as the parent(s) or guardian(s) of said minor child and which said minor child has or hereafter may acquire, either before or after reaching majority.

I/We also promise, to INDEMNIFY, REIMBURSE, DEFEND, and HOLD HARMLESS the Releases against any and all legal claims and proceedings of any description that may have been asserted in the past, or may be asserted in the future, directly, including damages, costs and attorneys' fees, arising from personal injuries to my child or property damage resulting from my child's participation in the Town/City and/or Public Schools of Oxford voluntary or recreation programs or administration of first aid.

I/We further affirm that I/We have read this Parental Consent, Release from Liability and Indemnity Agreement, and that I/We understand the contents of this Agreement. I/We understand that my child's participation in these programs is voluntary and that my child and I/We are free to choose not to participate in said programs. By signing this Agreement, I/We affirm that I/We have decided to allow my child to participate in the Town/City and/or Public Schools' athletic or recreation programs with full knowledge that the Releases will not be liable to anyone for personal injuries and property damage my child or I/We may suffer in voluntary Town/City and/or Public School athletic or recreation programs.

SIGNED:

____

Parent(s) or Guardian(s) of: Date:

____

Student/Participant

This form may not be altered

AUTHORIZATION TO ADMINISTER MEDICATION TO A CHILD

TO BE COMPLETED BY PARENT/GUARDIAN

Child's Name: ____ Grade: ___________ Age: __________

Food/Drug Allergies: ____

Diagnosis (at parent's discretion):____

Name of Licensed Prescriber: ____

Address: _____________________________ City: ___________ State: _____ Zip Code: _________________

Business Telephone: ____________________________ Emergency Telephone: _________________________

Name of Medication: ______________________________ Dose given: _________________________

Route of Administration: ___________________________ Frequency: _________________________________

Date Ordered: ____________________________________ Duration of Order: ____________________________

Quantity Received: _____________ Expiration Date of Medication Received: __________________________

Special Storage Requirements: ____

Specific Directions (e.g., on empty stomach / with water): ____

____

Specific Precautions: ____

Possible Side Effects / Adverse Reactions: ____

____

Other Medications Child is Receiving (at parent's discretion): ______________________________________

____

Location where medication Administration will occur: ____

Parent/Guardian Name: ____

Address: _____________________________ City: ___________ State: _____ Zip Code: _________________

Home Telephone: _______________________________ Work Telephone: ______________________________

Cell Number: ___________________________________ Emergency Telephone: _________________________

OVER →

AUTHORIZATION TO ADMINISTER MEDICATION TO A CHILD (2)

I hereby authorize ________________________ to administer, to my child ______________________ the
Name of Camp Name of Child
medication(s) listed on the previous page, in accordance with 105 CMR 430.160.

105 CMR 430.160(A)

Medication prescribed for campers shall be kept in original containers bearing the pharmacy label, which shows the date filling, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patients, the name of the prescribing practitioner, the name of the prescribed medication, directions for use and cautionary statements, if any, contained in such prescription or required by law, and if tablets or capsules, the number in the container. All over the counter medications for campers shall be kept in the original containers containing the original label, which shall include the directions for use.

105 CMR 430.160(C)

Medication shall only be administered by the health supervisor* or by a licensed health care professional authorized to administer prescription medications. The health care consultant shall acknowledge in writing the list of medications administered at the camp. If the health supervisor is not a licensed health care professional authorized to administer prescription medications, the administration of medication shall be under the professional oversight of the health care consultant. Medication prescribed for campers brought from home shall only be administered if it is from the original container, and there is written permission from the parent/guardian.

105 CMR 430.160(D)

When no longer needed, medications shall be returned to a parent or guardian whenever possible. If the medication cannot be returned it shall be destroyed.

*Health Supervisor – A person who is at least 18 years of age, specifically trained and certified in at least current American Red Cross First Aid (or its equivalent) and CPR, has been trained in the administration of medications and is under the professional oversight of a licensed health care professional authorized to administer prescription medications.

Parent/Guardian Signature: ____ Date: ________________