



Chestertown RiverArts
315 High Street, Suite 106
Chestertown, MD 21620
chestertownriverarts.org
410 778 6300

Registration and Release Form Winter 2019

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Registration: Register by mail, email, phone or in person. Office hours: Tuesday - Friday 11-5:30, Saturday 10 – 5:30.
info@chestertownriverarts.org / 410 778 6300

Payment: Payment must be made prior to registration, or within three working days if registered by phone. Paid registrations will have priority over non-paid if a section fills up.

Minimum 2 days per week

****Payment due one week prior**

- | | |
|---|--|
| <ul style="list-style-type: none">• Week One: February 4-7• Week Two: February 11-14• Week Three: February 18-21• Week Four: February 25-28• Mid Term Break: March 4-7
(no after school this week) | <ul style="list-style-type: none">• Week Five: March 11-14• Week Six: March 18-21• Week Seven: March 25-28• Week Eight: April 1-4• Make up days: April 8-12
(this week only if there are snow days) |
|---|--|

PLEASE CHECK HOW MANY DAYS PER WEEK

- ___ \$520: 4 days week
___ \$408: 3 days week
___ \$272: 2 days week

Please use a separate form for each child.

10% Family Discount for more than one child and for RiverArts & KidSPOT Kids Club Members

Choose session(s): Monday-Thursday Monday Tuesday Wednesday Thursday

Child's Name: _____ Age: _____

Parent / Guardian's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone Number: _____ Email Address: _____

Is there anything special we should know about your child? _____

Total Amount Pre-Paid _____ Or Weekly Payment Amount: _____



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Release of claims: This registration is a release of all liability. In case of accident, property losses or illness, I will not hold Chestertown RiverArts, or persons employed by or involved with Chestertown RiverArts, Inc., responsible. This release covers classes at RiverArts, or the Clay Studio and any off-site facilities where classes are held. I will be fully responsible for the security and care of my personal property. I have read and agree to the above Registration and Release.

Signature: _____

Please make check payable to:

Chestertown RiverArts 315 High Street, Suite 106, Chestertown, MD 21620

You can stop by or call 410-778-6300 to pay with a credit card

Health Form and Parent Agreement Form also required



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Parent Agreement Form

Child's Name: _____

Please read carefully, sign and return with your Health and Registration forms:

I give permission for my child to participate in all KidSPOT After School activities including all field trips and special activities. I consent that any photographs taken of him/her are the property of Chestertown RiverArts and KidSPOT and may be reproduced and published, as RiverArts desires, free of any claim on my part.

In case of emergency, I authorize the instructor(s) or assigned personnel to secure the services of a doctor if necessary, to protect my child's well-being.

Food, and Behavior:

Snacks will be provided. I understand that if my child has special dietary needs it is my responsibility to disclose that fact, and to provide an appropriate snack.

KidSPOT After School is a fun place, but we also need it to be a safe place. Students who are excessively disruptive or who engage in dangerous behavior may be prohibited from participating in some or all activities.

I give permission for the following (check all that apply):

____ Obtaining emergency medical care and/or transport to hospital

____ Administration of minor first aid

____ Walks and Trips

Parent/Guardian's Signature: _____ Date: _____

Please Print Name: _____

HH Garnett Elementary Families Only:

I give permission for KidSPOT After School to pick up my child from HH Garnett Elementary on the days they will attend KidSPOT After School. I understand that a representative of the camp will escort the children from the school to the KidSPOT facility at 315 High Street, in Chestertown.

Parent/Guardian's Signature: _____ Date: _____



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Health Form

To be completed by parent or guardian - please print clearly and complete both sides

Child's Name: _____ Child's Sex: _____ Grade: _____ Age: _____ Date of Birth: _____

Child's Home Address - Street, City, State, Zip _____

Parent or Guardian #1 _____ Parent or Guardian #2 _____

Parent or Guardian #1 Home address _____ Parent or Guardian #2 Home address _____

Email _____ Email _____

Phone (h) (c) (w) _____ Phone (h) (c) (w) _____

Person to Contact in Emergency (other than parent): _____ Phone: _____

Name of Child's Physician: _____ Phone: _____

Name of Family's Medical Insurance Company: _____ Policy #: _____

Health Information Necessary for Child's Protection and Care:

Please circle Yes or No. If YES please provide details; use separate page if necessary

Do you know of any health factor that makes it advisable for your child to follow a limited program of physical activity while at KidSPOT After School?

Recent childhood diseases or infectious diseases: YES NO Provide Details: _____

Asthma, heart condition, diabetes, seizure: YES NO Date & Details: _____

Other physical conditions: YES NO Details: _____

Allergies to Medications: YES NO Details: _____

Allergies to Foods: YES NO Details: _____

Environmental allergies (bee stings, hayfever, etc.): YES NO Details: _____



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Medical Information

My child will be bringing an Epi-Pen Reason:

My child will be bringing an Albuterol Inhaler (for PRN or as needed)

RiverArts' KidSPOT After School requires Epi-Pens and PRN Inhalers to be carried at all times. Please provide a fanny/waist pack for carrying.

We are not allowed to give your child any medication, including aspirin, or apply sunscreen

The following must be completed and signed for your child to attend:

This health history is correct so far as I know, and the person herein described has permission to engage in all activity, except as noted by me. If a serious emergency occurs, it might be necessary for a physician to attend to your child before RiverArts KidSPOT After School staff is able to contact me or my designated physician. Such care can be provided ONLY If you sign the following:

AUTHORIZATION FOR MEDICAL TREATMENT:

I hereby give permission to the physician selected by the director of RiverArts KidSPOT After School Program to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above. I understand that any medical expenses beyond the limits of Chestertown RiverArts' participant medical coverage will be billed directly to me or my insurance company.

Parent / Guardian Signature _____

Please Print Name: _____

Date: _____

Relationship to child: _____

A signed, printed copy of this form be on file at Chestertown RiverArts or must accompany your child on the first day of KidSPOT After School.