



**FOR VOYAGER YOUTH PROGRAM STAFF USE ONLY**

Date Received \_\_\_\_\_ Staff Initials \_\_\_\_\_

- Enrollment Form \_\_\_\_\_
- Contact Authorization \_\_\_\_\_
- Health Status Form \_\_\_\_\_
- Immunization Record \_\_\_\_\_
- Permission Form \_\_\_\_\_
- Behavior Contract \_\_\_\_\_
- Collection Policy \_\_\_\_\_

**ENROLLMENT FORM**

Date: \_\_\_\_\_ Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Child's Age: \_\_\_\_\_ Child's Gender: Boy / Girl

Mailing Address: \_\_\_\_\_ Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Hours: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Work Hours: \_\_\_\_\_

Email Address: \_\_\_\_\_ Cell Phone(s): \_\_\_\_\_

Person other than parent to be notified in an emergency situation when parents are not available:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Name(s) of person(s) other than parent to whom the child may be released:

1. \_\_\_\_\_ Phone \_\_\_\_\_ 2. \_\_\_\_\_ Phone \_\_\_\_\_

3. \_\_\_\_\_ Phone \_\_\_\_\_ 4. \_\_\_\_\_ Phone \_\_\_\_\_

Persons unable to pick up child(ren) \_\_\_\_\_

I am interested in applying for scholarship/financial help: Yes No

Camp my child is enrolling in:

- 1.  Cannot swim at all  Is a marginal swimmer  Is a strong swimmer
- 2.  May walk home from Voyager  Needs to wait to be picked up
- 3.  Gets car sick  Does not get car sick

Issues or concerns Voyager staff should be aware of: \_\_\_\_\_

I have read the Parent Handbook and agree to the Voyager Youth Program Policies and Procedures.

\_\_\_\_\_  
 Parent or legal guardian signature

\_\_\_\_\_  
 Date

***PLEASE ANSWER THE FOLLOWING QUESTIONS FOR VOYAGER YOUTH PROGRAM GRANT APPLICATION PURPOSES***

I am currently... (circle response)

- 1) Married A single parent
- 2) Part-time employed Full-time employed Other
- 3) Ridgway employed Ouray employed Telluride employed Montrose employed Self-employed, work mainly outside Ouray County Other
- 4) Living in Ouray Living in Ridgway Living outside Ouray County

My spouse is currently... (circle response)

- 5) Part-time employed Full-time employed Other N/A
- 6) Ridgway employed Ouray employed Telluride employed Montrose employed Self-employed, work mainly outside Ouray County Other



## CONTACT AUTHORIZATION

I, \_\_\_\_\_, am the parent or legal guardian of \_\_\_\_\_, hereinafter "the Applicant".

I request that the Applicant be authorized to attend the Voyager Youth Program.

I hereby give permission for the staff of the Voyager Youth Program to confer with the following persons and/or entities regarding applicant:

1. Any of Applicant's Teachers or other school officials;
  
2. Applicant's **physician(s)** who is \_\_\_\_\_;  
Please write name if applicable
  
3. Applicant's **mental health professional** who is \_\_\_\_\_;  
Please write name if applicable
  
4. **Other caregivers** of Applicant who is/are \_\_\_\_\_.  
Please write name if applicable

\_\_\_\_\_  
Parent or legal guardian signature

\_\_\_\_\_  
Date



**FOR VOYAGER YOUTH PROGRAM STAFF USE ONLY**

- Allergies \_\_\_\_\_
- Asthma \_\_\_\_\_
- Medication \_\_\_\_\_
- Other Conditions \_\_\_\_\_
- Notes \_\_\_\_\_

**STATEMENT OF HEALTH STATUS**

Type of Facility: **School Age Child Care**

The child care facility must obtain for every child who enrolls in child care programs a signed dated statement of the child's current health status which indicates the abilities and/or limitations to participate in a regularly scheduled child care program. This report is to be filled out by a parent or legal guardian of the child.

Child's Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Past Illness- Check those the child has had and give approximate dates:

- Chicken Pox \_\_\_\_\_  Ruseola \_\_\_\_\_  Rubella \_\_\_\_\_  Rheumatic Fever \_\_\_\_\_  Asthma \_\_\_\_\_  Hay Fever \_\_\_\_\_
- Diabetes \_\_\_\_\_  Mumps \_\_\_\_\_  Epilepsy \_\_\_\_\_  Whooping Cough \_\_\_\_\_  Poliomyelitis \_\_\_\_\_
- Other \_\_\_\_\_

Comments: \_\_\_\_\_

Surgery/Accident/Illness/Chronic Heart Problems: \_\_\_\_\_

Describe any physical or medical condition requiring special attention: \_\_\_\_\_

Medication(s) prescribed: \_\_\_\_\_

Allergies: \_\_\_\_\_ and prescribed routine: \_\_\_\_\_

If tuberculin test given: Date: \_\_\_\_\_ Results: \_\_\_\_\_ If chest x-ray taken: Date: \_\_\_\_\_ Results: \_\_\_\_\_

Vision: \_\_\_\_\_ Hearing: \_\_\_\_\_

Date of most recent examination of the child: \_\_\_\_\_ Name of Health Care Professional: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Phone

Hospital preferred for emergency treatment: \_\_\_\_\_ Address: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Please record immunizations and dates administered on the Colorado Department of Health Certification of Immunization and attach to this form.

I \_\_\_\_\_ give consent for my child's health care provider and child care provider to discuss my child's health concerns in order to best care for my child.

\_\_\_\_\_  
 Parent or legal guardian signature

\_\_\_\_\_  
 Date

**COLORADO LAW REQUIRES THIS FORM BE COMPLETED AND PROVIDED**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Parent/Guardian \_\_\_\_\_

**COLORADO DEPARTMENT OF HEALTH – CERTIFICATE OF IMMUNIZATION**

MINIMUM DOSES REQUIRED				VACCINE	ENTER DATES EACH IMMUNIZATION WAS GIVEN			
VACCINE	Preschool (15mo-4yrs)	Grades K-6 (5-11yrs)	Grades 7-12 (12-18yrs)	DIPHTHERIA – TETANUS – PERTUSSIS (DTP)				
DTP/Td/DT	3	4	4	- OR -				
Polio	2	3	3	TETANUS – DIPHTHERIA (Td, DT)				
Measles*	1	1	2					
Mumps*	1	1	2					
Rubella*	1	1	2	POLIO				
Hib**	1							
Any student starting or completing the vaccine series within 6 months of first enrollment in a Colorado school may be certified with:				HAEMOPHILUS INFLUENZA TYPE b** (ENTER MONTH, DAY, YEAR)				
VACCINE	Preschool (15mo-4yrs)	Grades K-6 (5-11yrs)	Grades 7-12 (12-13yrs)	MEASLES*			Written evidence of laboratory tests showing immunity to measles, mumps, and rubella is acceptable.  Attach written proof to this certificate or record test results and dates in the boxes at left.	
DTP/DT	3	3		(ENTER MONTH, DAY, YEAR)				
CR				MUMPS*				
Td (Age 7+)		2	2	(ENTER MONTH, DAY, YEAR)			TO THE BEST OF MY KNOWLEDGE, THIS PERSON HAS RECEIVED THE ABOVE IMMUNIZATIONS.	
Polio	2	2	2	RUBELLA*				
Measles*	1	1	2	(ENTER MONTH, DAY, YEAR)				
Mumps*	1	1	2					
Rubella*	1	1	2				SIGNED _____ (PHYSICIAN, NURSE OR SCHOOL HEALTH AUTHORITY)  IMMUNIZATION REQUIREMENTS  TITLE _____ DATE _____  ARE MET	
Hib**	1							

\* Measles, mumps and rubella vaccines must have been administered on or after the first birthday to be acceptable for certification.  
 Beginning July 1, 1992, 7<sup>th</sup> graders and college freshmen born since January 1, 1957 must have 2 measles doses, 2 mumps doses and 2 rubella doses: if the student received a 2<sup>nd</sup> measles dose prior to July 1, 1992, the 2<sup>nd</sup> rubella and mumps doses are not required. The measles, mumps and rubella doses must have been administered on or after the first birthday and at least one month apart. By July 1, 1995 all college students born since January 1, 1957 must comply. By July 1, 1997 all students in grades 7-12 must comply.  
 \*\* One Hib vaccine dose must have been administered at age 12 months or older. Children age 5 and older are exempt from Hib requirements.  
 Your doctor or clinic may recommend additional doses.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**STATEMENT OF EXEMPTION TO IMMUNIZATION LAW**

IN THE EVENT OF AN OUTBREAK, EXEMPTED PERSONS WILL BE SUBJECT TO EXCLUSION FROM SCHOOL AND QUARANTINE.

**MEDICAL EXEMPTION**

THE PHYSICAL CONDITION OF THE ABOVE NAMED PERSON IS SUCH THAT IMMUNIZATION WOULD ENDANGER LIFE OR HEALTH, OR IS MEDICALLY CONTRAINDICTED DUE TO OTHER MEDICAL CONDITIONS.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_  
 (PHYSICIAN)

**RELIGIOUS EXEMPTION**

PARENT OR GUARDIAN OF THE ABOVE NAMED PERSON OR THE PERSON HIMSELF/HERSELF ADHERES TO A RELIGIOUS BELIEF OPPOSED TO IMMUNIZATIONS.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_  
 (PARENT OR GUARDIAN OR EMANCIPATED STUDENT/CONSENTING MINOR)

**PERSONAL EXEMPTION**

PARENT OR GUARDIAN OF THE ABOVE NAMED PERSON OR THE PERSON HIMSELF/HERSELF ADHERES TO A PERSONAL BELIEF OPPOSED TO IMMUNIZATIONS.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_  
 (PARENT OR GUARDIAN OR EMANCIPATED STUDENT/CONSENTING MINOR)



FOR VOYAGER YOUTH PROGRAM STAFF USE ONLY

<input type="checkbox"/> Transportation	<input type="checkbox"/> Immunization Records
<input type="checkbox"/> Participation in Activities	<input type="checkbox"/> Field Trips
<input type="checkbox"/> Apply Sunscreen & Bug Spray	<input type="checkbox"/> Media Release
<input type="checkbox"/> Emergency Medical Care	<input type="checkbox"/> Movies
<input type="checkbox"/> Administer Medication	

## PERMISSION AND AUTHORIZATION FORM

Check the "Y" box for each item you give permission.  
 Check the "N" box for any item permission is **not** given.

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

### Transportation

<input type="checkbox"/> Y	<input type="checkbox"/> N
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I give my permission for authorized Voyager Staff to transport my child to and away from program headquarters (Ridgway or Ouray School). If necessary, I also give permission to Voyager Staff to transport my child in a personally owned vehicle.

### Participation in Activities

<input type="checkbox"/> Y	<input type="checkbox"/> N
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I give my permission for my child to participate in program activities except for the following:

\_\_\_\_\_

### Apply Sunscreen & Bug Spray

<input type="checkbox"/> Y	<input type="checkbox"/> N
----------------------------	----------------------------

I give my permission to Voyager Youth Program staff to apply sunscreen and bug spray on my child as needed.

### Emergency Medical Care

<input type="checkbox"/> Y	<input type="checkbox"/> N
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I hereby give my permission to program staff to call for medical or surgical care for my child should an emergency arise. It is understood that a conscientious effort will be made to locate me before emergency action will be taken, but if this is not possible, I will accept responsibility for the expenses of emergency treatment or care.

### Administer Medication (if applicable- only necessary if your child takes medication)

<input type="checkbox"/> Y	<input type="checkbox"/> N
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I give my permission to program staff to administer physician prescribed medication to my child. I agree to provide the medication in its original pharmacy container with my child's name and medication name and dosage clearly marked.

### Immunization Records

<input type="checkbox"/> Y	<input type="checkbox"/> N
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I confirm that my child's immunization records are kept on file with Ouray / Ridgway School (circle one) and subsequently give my permission for a copy to be released to Voyager Youth Program.

### Field Trips

<input type="checkbox"/> Y	<input type="checkbox"/> N
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I give my permission for my child to go on field trips away from the premises of the program headquarters (Ridgway or Ouray School), in the company of program staff, whether on foot or by vehicle.

### Media Release

<input type="checkbox"/> Y	<input type="checkbox"/> N
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I give my permission for my child to be photographed by program staff and/or local press as he/she is engaged in program activities for the purpose of program promotion and communication.

### Movies

I give my permission for my child to watch the following rated movies:

<input type="checkbox"/> Y	<input type="checkbox"/> N
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Rated **G**

<input type="checkbox"/> Y	<input type="checkbox"/> N
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Rated **PG**

This Permission and Authorization form will be effective from the date signed below, up to one year. I understand that I may, at any time, revoke this Permission and Authorization form by submitting written notification to Voyager Youth Program staff.

\_\_\_\_\_  
 Parent or legal guardian signature

\_\_\_\_\_  
 Date

## BEHAVIOR CONTRACT

Students and parents should read the following information *together* and sign below:

### YOUR RIGHTS & RESPONSIBILITIES

You have the *right* to:

- A safe VYP experience and environment
- Make choices
- Your own thoughts and ideas
- Be treated fairly
- Be yourself

You are *responsible* for:

- Maintaining a safe VYP experience and environment
- The consequence of your choices
- Respecting others
- Your own actions

### CODE OF CONDUCT

As a participant in Voyager Youth Program I will:

- Respect self, others and the environment
- Arrive prepared and willing to participate with a positive, can-do attitude
- Do all I can to make sure everyone (myself included) has a great Voyager experience

### GENERAL RULES

- You must get permission at all times from your group leader to leave the room or group
- Always wash your hands thoroughly with soap after going to the bathroom, before eating, after playing or before and after preparing food
- Keep your hands and feet to yourself at all times
- No rough play, foul language, or fighting will be tolerated.
- No throwing of any objects unless it is part of a game or activity
- Clean up after yourself

### DISCIPLINE POLICY

Voyager's discipline protocol consists of a color/consequence progression using four increments: green, yellow, orange, and red. All students have name cards that upon arrival are placed under the green "attendance" card. VYP wants students to focus on self-control and positive change, however, students who demonstrate repeated or excessive negative behavior will be asked to move their name to the yellow card representing an "official" warning. If this behavior persists, students are subsequently asked to move their name to the orange card indicating a "timeout" consequence from the current activity. Students do have the opportunity to earn their way back to green through positive behaviors. As a final consequence, persistent negative behavior results in moving to the red card requiring an indefinite timeout and communication with parent/guardian. Depending on the circumstances and severity of the behavior, this communication may take place immediately or may wait until pickup. As a last resort and at the discretion of the Program Director students who repeatedly receive red cards may not be allowed to attend the program for an appropriate amount of time. This decision will only be made following careful discussion between parents and Voyager Youth Program staff.

I understand that my conduct should be appropriate to the standards of Voyager Youth Program at all times and that failure to follow these guidelines may result in my dismissal from the program. Staff will counsel students whenever possible to avoid dismissal.

**I have read and understand the conditions of this agreement.**

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

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

## Voyager Youth Program Collection Policy

Voyager Youth Program is a nonprofit which exists to serve the families of Ouray County by providing quality programming for youth. These programs are only able to be maintained by the receipt of timely payments made by the participants. It is the responsibility of the participant families to help maintain the financial well being of the program and thereby play an important part in its success.

1. Invoices are sent out for the prior month's services stating the balance due before the end of the month.
2. 30 days - If payment is not made by the end of the month, parents are required to notify Voyager of the date funds will be received. Any arrangement must include a partial payment to be made before the account is 45 days past due.
3. 45 days - If no payment has been made and/or no contact has been made, a letter is sent to parents asking them to contact the office to make payment arrangements and notifying the parent if they do not contact us and/or the first arranged payment is not received by the 60<sup>th</sup> day due, services will be stopped. Any account with balances 45 days past due is assessed a \$20 late charge (waived if payment arrangements are made and a partial payment received).
4. 60 days - If no contact is made OR if the first arranged payment is not received a letter is sent stating that the child is ineligible to receive services from Voyager until such time as payment is received. Further, if arrangements are not made AND the first arranged payment is not received before the account becomes 90 days past due the account will be turned over to a collection agency and reported to the credit bureau. An additional \$20 late fee is assessed.
5. 90 days - account turned over to the collection agency.

NOTE: Help to offset the cost of childcare can be applied for through Social Services. Call 626-2299 for more information.

Scholarships may be available. Contact the Voyager office at 626-4279 for more information.

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I have read and agree to the preceding Collection Policy

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Signature

Date

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Parent's name

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Child/Children's name