

Home of the "Mustangs"
MAINE CONSOLIDATED SCHOOL #10
10 Spring Valley Road PO Box 50010 Parks, AZ 86018
Superintendent - - Dr. Justin Roberson
(928) 635-2115 Fax (928) 635-5320

EDCP Extended Day Care Program

EDCP is designed to provide care for your child, after school for a small fee.

Activities will include outdoor/indoor play, games, and there will be time allowed for homework. Time will be given right after school to do homework. This will be a quiet time. An afternoon snack will be provided.

Our staff is CPR/first aid certified. We are licensed by the state of Arizona.

Rules must be followed to provide a safe and comfortable environment for every child.

You must sign in/out each day. You must sign at least first initial and last name. Please instruct others who may drop them off or pick them up to do the same.

***Hours are Monday through Thursday from 3:30 pm to 6:00 pm.**

Before your child may attend, a registration fee and completed registration packet must be turned into the office. **The registration fee for one child is \$15.00 or \$25.00 per family for the school year.**

COST: \$2.00 per half hour for each child. There will be an additional charge (\$1.00 per minute) for children picked up after 6:00 pm.

You will receive monthly account balances. Please pay these upon receipt. If paying with a check, please make it out to MCSD and put EDCP in the memo. Please give payment to the front office.

Thank you for your interest in EDCP!

Dr. Justin Roberson
Principal and Superintendent



CDC/SGH# or name: _____

**Arizona Department of Health Services
Bureau of Child Care Licensing**

Emergency, Information and Immunization Record Card

Child's Name:	Date Enrolled:	Updated:
Home Address (#, Street, City, State, Zip Code):		Date Disenrolled:
Home Phone:	Date of Birth:	Sex: <input type="checkbox"/> male <input type="checkbox"/> female

Parent or Guardian Name:	Home Address (#, Street, City, State, Zip Code):
Cell Phone (optional):	Contact Telephone Number:

Parent or Guardian Name:	Home Address (#, Street, City, State, Zip Code):
Cell Phone (optional):	Contact Telephone Number:

I authorize the following individuals to collect my child from the facility in case of emergency or if I cannot be contacted:
(Pursuant to R9-5-304.B, at least two contact persons are required.)

Name:	Contact Telephone Number:
Name:	Contact Telephone Number:
Name:	Contact Telephone Number:
Name:	Contact Telephone Number:

If Medical care is necessary, call:

Health Care Provider*	Name:	Contact Telephone Number:
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*A Health Care Provider is a physician, physician assistant or registered nurse practitioner.

I hereby give authority to any hospital or doctor to render immediate aid as might be required at the time for his/her health and safety.

In case of injury or sudden illness, I request that this individual be called first:	
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The following individual(s) may NOT remove my child from the facility:

Name(s):

Custody papers have been provided and are on file at the facility. yes no

Telephone Authorization Code (optional): _____

Immunization Information

(A licensee shall attach an enrolled child's written immunization record or exemption affidavit to the enrolled child's Emergency, Information and Immunization Record card.)

For information regarding current immunization requirements go to:
www.azdhs.gov/phs/immun/index.htm or contact the Arizona Immunization Program Office at (602)364-3630.

One of these items must accompany the EIIR card at all times:

<input type="checkbox"/>	Copy of current official documented immunization record attached
<input type="checkbox"/>	Religious Beliefs exemption form signed by parent/guardian attached
<input type="checkbox"/>	Medical Exemption form signed by physician and parent/guardian attached
<input type="checkbox"/>	Signed Laboratory Proof of Immunity form attached

Notification of immunizations needed sent to Parent(s) or Guardian(s):	mo /day/ yr	mo /day/ yr	mo /day /yr
Updated immunizations received and attached:	mo /day/ yr	mo /day/ yr	mo /day /yr

Medical Information

Is child allergic to food or other substances? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe symptoms, name foods or substances to be avoided, and the procedure to follow if reaction occurs:
Is child usually susceptible to infections and if so, what precautions need to be taken? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, list precautions:
Is child subject to convulsions and what should be our procedure if one occurs? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, specify procedure:
Is there any physical condition that we should be aware of and what precautions should be taken (heart trouble, foot problem, hearing impairment, hernia, etc.)? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, list precautions:
Additional comments:
Other special instructions:

This **Emergency Information and Immunization Record Card** is accurate and complete, front and back, and was provided by:

Parent/Guardian PRINTED Name:	SIGNED Name:	DATE: