F.R.I.E.N.D.S.
P.O. Box 1821
Richmond Hill, GA 31324
Phone: 888-508-1012
Fax: 888-558-9897
Email: info@friendsofcoastalga.com
Website: www.friendsofcoastalga.com

Social Skills Programs

Enrollment Application and Policies

2017 - 2018

Learning Through Laughter and Friendship

F.R.I.E.N.D.S. Program Enrollment Application

Please select the program(s) below in which your child will be enrolling

- ☐ Out and About with F.R.I.E.N.D.S
- ☐ Fitness with F.R.I.E.N.D.S.
- ☐ Cooking with F.R.I.E.N.D.S.
- ☐ Parents Night Out
- ☐ Employing F.R.I.E.N.D.S.
- ☐ Teen Club
- ☐ Caring for F.R.I.E.N.D.S.

CHILD INFORMATION

Child's Name	Date of Birth	Age	Gender ◯ Male ◯ Female	Race

Child's Home Address (include street, city, state, and zip)	Home Phone Number	
Parent/Guardian Name 1	Relationship to Child	
Home Address (Include street, city, state, and zip)	Home Phone Number	
Email Address	Cell Number	Work Number
Employer Name	Employer Address	
Parent/Guardian Name 2	Relationship to Child	
Home Address (Include street, city, state, and zip)	Home Phone Number	
Email Address	Cell Number	Work Number
Employer Name	Employer Address	

Child lives with:

◯ Mother ◯ Father ◯ Both Parents ◯ Legal Guardian

T-SHIRT SIZES

(T-Shirts are available for select programs. Select **one** size below in either Youth or Adult Size)

YOUTH:	◯ X Small	◯ Small	◯ Medium	◯ Large	◯ X Large	
ADULT:	◯ X Small	◯ Small	◯ Medium	◯ Large	◯ X Large	◯ Other: _____

MODEL RELEASE

F.R.I.E.N.D.S. ◯ **may** ◯ **may not** use photographs, images, or sound recordings of my child for advertising, publicity, or any other lawful purpose (includes F.R.I.E.N.D.S. Facebook postings of pictures and or pictures displayed on the F.R.I.E.N.D.S. website).

EMERGENCY CONTACT AND RELEASE PERSONS

Please notify F.R.I.E.N.D.S. if an Emergency Release Person will pick up your child on a given day. For the safety of your child, we will request all authorized release persons to provide Government-issued photo identification (driver's license) at the time of pick-up. All persons below must be 18 or older, unless he/she is the parent of the child.

Name Emergency Contact 1	Name Emergency Contact 2
Relationship to Child	Relationship to Child
Home Address (include street, city, state, and zip)	Home Address (include street, city, state, and zip)
Home Phone Number	Home Phone Number
Cell Number	Cell Number
Employer	Employer
Employer Address	Employer Address
Work Number	Work Number

PARENT/GUARDIAN LICENSE EXEMPTION NOTIFICATION

I have been advised and understand that the F.R.I.E.N.D.S. Social Skills Programs are not licensed and are not required to be licensed by the Bright from the Start division of the Georgia Department of Early Care and Learning.

Parent/Guardian Print	Date
Parent/Guardian Signature	Date
Administrator/Designee Signature	Date

Per the Bright from the Start Georgia Department of Early Care and Learning, F.R.I.E.N.D.S. is **required** to provide and retain written notice regarding our facility not being required to be licensed by the state of Georgia.

PROGRAM ELIGIBILITY

To participate in these programs, your child must meet the following criteria:

1. Must be between the ages of 8 and 21 (Age 13-21 for the Employing FRIENDS program)
2. Must be able to function in a 3:1 ratio (one staff member per every 3 children)
3. Must exhibit non-violent behaviors (includes non-self injurious behaviors)
4. Must have a low occurrence of wandering, bolting, or running
5. Must be toilet trained.

APPLICATION INSTRUCTIONS

1. Complete F.R.I.E.N.D.S. Program application and email it to info@friendsofcoastalga.com or fax it to 888-558-9897. New students must include IEP or Psychological Evaluation with application.
2. Contact selected funding source and complete their funding application.

PROOF OF DIAGNOSIS

F.R.I.E.N.D.S. Social Skills Programs are designed for children with Autism and/or Developmental Disabilities. Funding sources require proof of diagnosis in the form of an IEP or Psychological Evaluation prior to providing financial assistance to cover the cost of these programs. An IEP or Psychological Evaluation is not required for children who have previously attended these programs and/or have previously completed funding application with B&B Services, Easter Seals, Gateway, or Ogeechee Behavioral Health. Applications for new students will not be processed without a copy of the IEP or Psychological Evaluation being on file. Please check the appropriate box below regarding your child's IEP/Psychological Evaluation status.

◯ New Student – IEP and/or Psychological Evaluation attached to application

◯ Returning Student – IEP and/or Psychological Evaluation on file with FRIENDS.

PROGRAMS AND SESSION RATES

Select the program(s), session location, and session(s) your child will attend below.

Out and About with FRIENDS ◯ **Savannah** ◯ **Swainsboro** ◯ **Richmond Hill**

☐ **1st and 3rd Saturday**
◯ Session A 10 AM-1 PM
◯ Session B 2PM-5 PM

☐ **2nd and 4th Saturday**
◯ Session C 10 AM-1 PM
◯ Session D 2 PM-5 PM

2 Sessions per month @ $60 per session/$120 per month/$1,140 for 10 months
- ☐ Summer Session (August) 2 Sessions - $120.00
- ☐ Fall Quarter (September – November) 6 Sessions - $360.00
- ☐ Winter Quarter (December – February) 5 Sessions - $300.00
- ☐ Spring Quarter (March – May) 6 Sessions - $360.00

Overall Session Total: $ _____

Parents Night Out ◯ **Savannah** ◯ **Swainsboro** ◯ **Richmond Hill**

☐

Held every 4th Saturday of the Month from 5:00-9:00 PM

1 Session per month @ $55 per session/$55 per month/$550 for 10 months
- ☐ Summer Session (August) 1 Session - $55.00
- ☐ Fall Quarter (September – November) 3 Sessions - $165.00
- ☐ Winter Quarter (December – February) 3 Sessions - $165.00
- ☐ Spring Quarter (March – May) 3 Sessions - $165.00

Overall Session Total: $ _____

Fitness with FRIENDS ◯ **Savannah** ◯ **Richmond Hill**

Savannah
◯ **Mondays** 4:30-5:30 Ages: 12-21
◯ **Wednesdays** 4:30-5:30 Ages: 8-11

Richmond Hill
◯ **Tuesdays** 5:00-6:00 Ages: 12-21
◯ **Thursdays** 5:00-6:00 Ages: 8-11

1 Session per week @ $20 per session/$80 per month/$740 for 10 months
- ☐ Summer Session (August) 4 Sessions - $80.00
- ☐ Fall Quarter (September – November) 11 Sessions - $220.00
- ☐ Winter Quarter (December – February) 10 Sessions - $200.00
- ☐ Spring Quarter (March – May) 12 Sessions - $240.00

Overall Session Total: $ _____

Employing FRIENDS (On-Site Vocational Training at Carey Hilliard's Skidaway Rd Restaurant)

◯ **Mondays** 4:30-6:30

◯ **Tuesdays** 4:30-6:30

◯ **Wednesdays** 4:30-6:30

◯ **Thursdays** 4:30-6:30

1-Two Hour Session per week @ $50 per session/$200 per month
$1,900 for 10 months. No sessions during Christmas break.

☐ Summer Session (August) 4 Sessions - $200.00
☐ Fall Quarter (September – November) 12 Sessions - $600.00
☐ Winter Quarter (December – February) 10 Sessions - $500.00
☐ Spring Quarter (March – May) 12 Sessions - $600.00

Overall Session Total: $ _____

Cooking with FRIENDS ◯ **Savannah** ◯ **Richmond Hill**

Savannah
◯ **Mondays** 4:30-5:30 Ages: 8-11
◯ **Wednesdays** 4:30-5:30 Ages: 12-21
Richmond Hill
◯ **Tuesdays** 5:00-6:00 Ages: 8-11
◯ **Thursdays** 5:00-6:00 Ages: 12-21

1 Session per week @ $30 per session/$120 per month/$1,140 for 10 months

☐ Summer Session (August) 4 Sessions - $120.00
☐ Fall Quarter (September – November) 12 Sessions - $360.00
☐ Winter Quarter (December – February) 10 Sessions - $300.00
☐ Spring Quarter (March – May) 12 Sessions - $360.00

Overall Session Total: $ _____

$30 annual, non-refundable registration fee due with Cooking with FRIENDS application.

Caring for FRIENDS (one-on-one staff/student ratio) ◯ **Savannah** ◯ **Richmond Hill**

☐

Minimum of 3 hours per session @ $13 per hour. Estimate hours/sessions below.

☐ Summer Session (August)
Number of Sessions _____ Total Cost: $_____ Time: _____ - _____
☐ Fall Quarter (September – November)
Number of Sessions _____ Total Cost: $_____ Time: _____ - _____
☐ Winter Quarter (December – February)
Number of Sessions _____ Total Cost: $_____ Time: _____ - _____
☐ Spring Quarter (March – May)
Number of Sessions _____ Total Cost: $_____ Time: _____ - _____

Overall Session Total: $ _____

Teen Club (Ages 12-21) ◯ **Savannah** ◯ **Richmond Hill**

☐

Held every 2nd Friday of the Month in Richmond Hill and every 3rd Friday of the Month in Savannah.

1 Session per month @ $10 per session/$10 per month/$100 for 10 months

☐ Summer Session (August) 1 Session - $10.00
☐ Fall Quarter (September – November) 3 Sessions - $30.00
☐ Winter Quarter (December – February) 3 Sessions - $30.00
☐ Spring Quarter (March – May) 3 Sessions - $30.00

Overall Session Total: $ _____

GRAND TOTAL FOR ALL ENROLLED SESSIONS: $ _____

FUNDING SOURCES

Please select **one** funding source below. Contact your selected funding source to obtain their funding application. Due to new regulations, you can only apply for one funding source at a time. If you have been denied funding from your selected funding source, you will then be allowed to apply to another funding source. If you were unable to receive **any** funding from the sources listed below, please contact F.R.I.E.N.D.S. immediately.

◯ COMP Waiver	◯ NOW Waiver	◯ B&B Services
◯ Private Pay	◯ Easter Seals Family Support	
◯ Gateway	◯ Ogeechee Behavioral Health	

FUNDING SOURCES CONTACT INFORMATION

Easter Seals
Gus Morales, Family Support
7395 Hodgson Memorial Dr. Suite
101 Savannah, GA 31406
912-235-6463
gmorales@swga-easterseals.org

Gateway Behavioral Health Services
Verlena Hawkins, Family Support
941 E.G. Miles Parkway
Hinesville, GA 31313
912-876-0454
vhawkins@gatewaybhs.org

B & B Services
Lisa Waters, Family Support
P.O. Box 1040
Springfield, GA 31329
912-754-0817
lwaters@bandbcare.com

Ogeechee Behavioral Health
Joanna Harrison, Family Support
223 N. Anderson Dr.
Swainsboro, GA 30401
478-289-2673
jharrison@obhs-ga.org

FUNDING AGENCY REIMBURSEMENT

I understand that I am solely responsible for any session fees that are not paid by my selected funding source. I also understand that I am solely responsible for promptly communicating any changes in my child's schedule to F.R.I.E.N.D.S. staff which will result in my child missing any scheduled sessions. The cost of missed sessions, which have been paid by funding sources, will be refunded to the funding source.

PARENTAL CONSENT TO TRANSPORT

F.R.I.E.N.D.S. provides van transportation to/from scheduled outings for the following programs when applicable:

- Out and About with FRIENDS
- Parents Night Out
- Caring for FRIENDS (vehicle transportation as needed)
- Teen Club

Parents are responsible for transporting their child to/from the scheduled pick-up/drop off site. As a courtesy, parents are requested to be on time when dropping off and picking up their children for all scheduled sessions. A session schedule which includes dates, times, outing locations, and drop-off/pick up locations/times will be provided to all parents.

This is to verify that I understand that F.R.I.E.N.D.S. will not be held responsible in case of damage or loss of personal property, personal injury, and any and all claims that may result from any unforeseen accident or event occurring while en route to/from an outing or occurring during an outing in which I and/or my child will be attending.

Parent/ Guardian Print	Date
Parent/Guardian Signature	Date

MEDICAL INFORMATION

Child's Name	Date of Birth	Age

Height	Weight	Hair Color	Eye Color

Distinguishing Marks/Birth Marks

List all medication that will be administered regularly during camp

Special Dietary Needs and/or Dietary Restrictions

Allergies (list all that apply)

Medication Allergies	Reaction
Food Allergies	Reaction
Other Allergies	Reaction

Are any of the allergies severe or life-threatening? ◯ YES ◯ NO If YES, please provide special instructions below.

MEDICAL CARE PROVIDER/FACILITY

I hereby give consent for the facility to secure any and all necessary emergency medical care for my child. In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to transport my child by ambulance, seek medical attention, and consent to any necessary examination, anesthetic, medical diagnosis, surgery or treatment, and/or hospital care to be rendered to my child under the general supervision of any physician or surgeon licensed to practice medicine in the State of Georgia.

Parent/Guardian Signature	Date
Primary Care Physician's Name	Practice/Clinic Name and Address
Primary Care Physician's Phone Number	Preferred Hospital for Emergency Care
Health Insurance Provider and Policy Number	Secondary Health Insurance Provider and Policy Number

REQUEST FOR ADMINISTRATION OF MEDICATION

This form is valid for no longer than 12 months. One form must be completed for each medication

Regulations permit child care providers to dispense prescription and non-prescription medications to children in care under certain conditions. F.R.I.E.N.D.S. must receive prior written permission from the child's parent; written authorization from the child's physician may also be required. If possible, arrange the time of dosage to be when the child is at home.

NON-PRESCRIPTION MEDICATION: A child may receive only one dose of a non-prescription medication each day the child is in care, with the exception of topical medications such as creams and ointments. A licensed health care practitioner must approve the medication and dosage for the child to receive more than one dose during a single day.

PRESCRIPTION MEDICATION: Prescription medications must be stored in a container that has been labeled by the pharmacy or physician and which displays the child's name and an expiration date for the medication. The child may receive medication only according to the written instructions of the health care practitioner, as indicated in writing, or the instructions on the medication label and as provided below.

Check all that apply:

- ☐ Prescription Medication
- ☐ Non-Prescription Medication
- ☐ Refrigeration Required
- ☐ Topical product or lotion
- ☐ Food Supplement
- ☐ Modified Diet

Child's Name	Date of Birth	Weight
Name of Medication	Dosage	Administration Time(s) _____AM _____PM

Administration Duration From_____to _____
(Date) (Date)

I/We authorized the staff at F.R.I.E.N.D.S. to administer the above named medication to my/our child.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature(s)	Date

Each administration of medication will be documented by staff on separate form. All dosages must be recorded.