



2026 Summer Camp Registration Form
 109 Bucklin Street Providence RI 02907 | 7:00 AM - 5:00 PM

COMPLETE ONE FORM PER FAMILY

Camper Name: _____ **Date of Birth:** _____

Gender (circle one): Female Male Age: _____

Grade Entering: _____

Camper Name: _____ **Date of Birth:** _____

Gender (circle one): Female Male Age: _____

Grade Entering: _____

Camper Name: _____ **Date of Birth:** _____

Gender (circle one): Female Male Age: _____

Grade Entering: _____

Payment

Camp Fees:

Full Time Camper (\$231.00 tuition a week)

- DHS Pay No Yes Certificate # _____
- DHS Weekly Copayment _____

Please plan with the business office for automatic payments

In the event that DHS refuses payment, parents will be responsible for the fees incurred by your child's participation in WECC programming. By signing below, you as the parent/guardian agree to be financially responsible for the tuition amount. You must pay this fee weekly. Tuition is due on Fridays and must be paid whether children attend care or not.

I have read and understand my responsibility for payments of fees.

Parent/Guardian's Signature _____ Date _____

INTAKE FORM

PARENT/GUARDIAN/CLIENT NAME: _____

INCOME (circle the income range that best fits your annual GROSS income and household size*):

2024-2025 Income Limits**	Household Size			
	1	2	3	4
30% of AMI	0-23,600	0-27,000	0-30,350	0-33,700
30%-50% of AMI	23,601-39,350	27,001-45,000	30,351-50,600	33,701-56,200
50%-80% of AMI	39,351-62,950	45,001-71,950	50,601- 80,950	56,201-89-900
80% + of AMI	62,951+	71,951+	80,951+	89,901+
	5	6	7	8
30% of AMI	0-36,580	0-41,960	0-47,340	0-52,720
30%-50% of AMI	36,581-60,700	41,961-65,200	47,341-69,700	52,721-74,200
50%-80% of AMI	60,701-97,100	65,201-104,300	69,701-111,500	74,201-118,700
80% + of AMI	97,101+	104,301	111,501+	118,701

**Note household size includes any persons that live in your residence.*

FEMALE HEAD OF HOUSEHOLD: Yes No

GENDER: Male Female

ETHNICITY: Hispanic/Latino Not Hispanic/Latino

RACE (check all that apply):

White	Black/African American	Asian	American Indian/Alaskan Native	Hawaiian/Other Pacific Islander
American Indian/Alaskan Native & White	Asian & White	Black/African American & White	American Indian/Alaskan Native & Black/African American	Other Multi-Racial

Youth's Name _____ D.O.B. _____

Guardian's Name _____ Phone _____

Guardian's Name _____ Phone _____

AUTHORIZATION FOR PICK-UP and EMERGENCY CONTACT

The following people are authorized to pick-up my child. Those that are checked "Emergency Contact" may also be called in the event I cannot be reached. I understand Emergency Contacts **MUST be at least 18 years old and present a photo ID** to be copied and kept in the emergency file to sign out my child. Any other person **will not be allowed** to pick-up my child. If you have concerns about this, please see the Director of Youth Services.

Accommodations may be made with permission of the Director of Youth Services. ***PLEASE NOTE* State licensing requires at least one adult**, other than a child's parents to be listed in case of emergency.

1. Name _____

4. Name _____

Home _____ Cell _____

Home _____ Cell _____

Relationship to Child _____

Relationship to Child _____

____ **Emergency Contact also**

____ **Emergency Contact also**

2. Name _____

5. Name _____

Home _____ Cell _____

Home _____ Cell _____

Relationship to Child _____

Relationship to Child _____

____ **Emergency Contact also**

____ **Emergency Contact also**

3. Name _____

6. Name _____

Home _____ Cell _____

Home _____ Cell _____

Relationship to Child _____

Relationship to Child _____

____ **Emergency Contact also**

____ **Emergency Contact also**

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In consideration of admittance, I hereby authorize West End Community Center, Inc., to secure treatment for my child should an emergency arise during care. It is understood that a conscientious effort will be made by staff to notify me as soon as possible at the numbers I have provided.

Medical Provider _____ Member Name _____

ID Number _____

Name and Phone Number of the Contact Person _____

Parent Signature _____ * Date _____

Parent Signature _____ * Date _____

****Any changes to this form must be made in person by the person(s) whose signature appears above.***

WAIVER OF LIABILITY FOR FIELD TRIPS/SPECIAL EVENTS

I (parent/guardian) _____ give permission to participate in West End Community Center, Inc., field trips and/or special events. I hereby, for myself, executors and administrators, waive any and all claims to damages which I might have against the sponsors of the West End Community Center, its officers, advisors, agents, representatives, successors and assignees for any and all injuries suffered by my child while participating in West End Community Center activities.

Parent/Guardian's Signature _____

PHOTOGRAPH AND PUBLICATION GENERAL RELEASE

The undersigned hereby gives West End Community Center, Inc., a Rhode Island non-profit corporation with principal offices located at 109 Bucklin Street, Providence, RI, 02907, its legal representatives, successors and assignees, all persons and corporations acting with its permission or upon its authority or for whom it is acting, the absolute right and unrestricted permission to take, copyright, use, and publish photographs of or concerning the undersigned's child for any purpose the West End Community Center deems desirable.

Parent/Guardian's Signature _____

_____ Please **DO NOT** take any pictures of my child. (Initial) _____

GENERAL HEALTH INFORMATION

Is your child allergic to any food, medication, plants, insects, liquids or other substances?

No Yes

If yes, to what are they allergic?

For safety reasons, your child's name and allergy will be added to an allergy list posted in authorized locations throughout the Center, including, but not limited to, the kitchen, classroom, and Youth Program Director's office.

Does your child require and medication for an allergic reaction?

No Yes

I will provide the following: _____ Epi Pen _____ Medication

If yes, please explain and be sure to include the severity of your child's reaction

Child's Name _____

Parent/Guardian's Signature _____ Date _____

Program Director's Signature _____ Date _____

Parent/Provider Enrollment Agreement

Rev. 4/2023

This form is to be used by the parent and the provider when enrolling a CCAP-eligible or potentially eligible child at an approved DHS CCAP provider. One form must be completed per enrolled child. It must be completed and signed by the parent **and** the child care provider; a copy is to be kept by both parties. It is the **provider's responsibility** to submit this information to DHS via the Provider Portal before or during the first week of care. Once the enrollment is complete, the parent and the provider will receive an Enrollment notice.

CCAP Provider ID:	Provider Name:
Parent's Full Name:	Certificate Number:
Child's Full Name:	Child's DOB:

AGREED HOURS OF CARE					
Care Start Date:				Use this section when child's schedule is a split day	
Care End Date:					
Day	Start Time	End Time		Start Time	End Time
Sunday					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					

The undersigned Provider, hereafter referred to as "Provider" agrees to care for the above-named child for the period indicated in this enrollment. Provider further agrees that the days and times the child will attend were agreed upon by the Provider and the undersigned parent of the child.

The Provider agrees to accept the DHS payment based on the DHS authorization and approval provided to the family, either Full-Time, Three-Quarter Time, Half Time, or Quarter Time as payment in full.

Both parties agree and understand that any services provided in excess of authorized hours shall be the sole responsibility of the parent.

The undersigned parent agrees to pay his/her share of the child care cost (copayment) in accordance with the RI DHS rules and regulations specified in the notice sent by the RI DHS Child Care Assistance Program.

Signature of Parent

Date

Signature of Provider

Date

Provider Printed Name

Position/Title

Acuerdo de inscripción de padres/proveedores

Rev. 4/2023

Este formulario debe ser utilizado por el padre y el proveedor al inscribir a un niño elegible o potencialmente elegible para CCAP en un proveedor de CCAP aprobado por DHS. Se debe completar un formulario por niño inscrito. Debe ser completado y firmado por el padre y el proveedor de cuidado infantil; ambas partes deben conservar una copia. Es responsabilidad del proveedor enviar esta información al DHS a través del Portal del proveedor antes o durante la primera semana de atención. Una vez que se complete la inscripción, el padre y el proveedor recibirán un aviso de inscripción.

ID de CCAP:	Nombre del Proveedor:
Nombre de los Padres:	Núm. de certificado:
Nombre de la niña o niño:	Fecha de Nacimiento:

HORAS DE ATENCION ACORDADAS					
Fecha de Inicio de la Atención: Fecha de Finalización de la Atención:				Use esta sección cuando el horario del niño es un día dividido	
Día	Hora de Inicio	Hora de Finalización		Hora de inicio	Hora de Finalización
Domingo					
Lunes					
Martes					
Miércoles					
Jueves					
Viernes					
Sabado					

El Proveedor que suscribe, en lo sucesivo denominado "Proveedor", acepta cuidar al niño mencionado anteriormente durante el período indicado en esta inscripción. El proveedor también acepta que los días y horas en que asistirá el niño fueron acordados por el proveedor y el padre del niño que suscribe.

El proveedor acuerda aceptar el pago del DHS basado en la autorización y aprobación del DHS proporcionada a la familia, ya sea a tiempo completo, tres cuartos de tiempo, medio tiempo o un cuarto de tiempo como pago total.

Ambas partes acuerdan y entienden que cualquier servicio prestado en exceso de las horas autorizadas será responsabilidad exclusiva de los padres.

El padre que suscribe acepta pagar su parte del costo del cuidado infantil (copago) de acuerdo con las normas y reglamentos del RI DHS especificados en el aviso enviado por el Programa de asistencia para el cuidado infantil del RI DHS.

Firma del Padre

Fecha

Firma de Proveedor

Fecha

Nombre impreso del proveedor

Título / Ocupación