



South Florida Autism Center, Inc.

SATURDAY RESPITE PROGRAM 2017-2018

Program Handbook & Application

South Florida Autism Center, Inc. (SFA-Center)
18305 NW 75 Place * Hialeah, Florida 33015
Phone: (305) 823-2700 * Fax: (305) 823-2705
www.sfa-center.org

INTRODUCTION:

South Florida Autism Center, Inc. Mission Statement

It is the intention of SFA Center to provide a safe, positive and enriching experience for each child enrolled in our Saturday Respite Program. Our program is designed to provide parents with the option to give their children a worthwhile learning experience during teacher work days. A participant to teacher ratio of 3:1 is maintained at all times unless otherwise stated.

Program Hours

SFA Center Saturday Respite Program follows the South Florida Autism Center's year calendar. Services are available only on Saturdays as outlined below from 8 a.m. to 3 p.m.

POLICIES AND PROCEDURES

Roles and Responsibilities of each Parent:

Parents and guardians are responsible for the following:

- Timely payments of all program fees
- Participant pick up is no later than 3 p.m.
- Complete/update the SFA Center Registration Form
- Submit the required, non-refundable registration fee of \$25

A PARTICIPANT MAY BE DISMISSED FROM THE PROGRAM IF A PARENT DOES NOT MEET THE ABOVE RESPONSIBILITIES ON A CONSISTENT BASIS!

Discipline

Behaviors will be addressed on a case-by-case basis, consistent with the methodologies utilized by SFA-Center.

Dates of Operation:

There will be 8 sessions offered. Participants must register a month in advance. Dates are as follows:

- September 28
- October 14
- November 4
- December 9
- February 10
- March 10
- April 21
- May 12

Hours of Operation:

Selected Saturdays from 8:00 a.m. to 3:00 p.m.

Hurricane Policy/Center Closures:

The Center programs are not part of Miami-Dade Public Schools. SFA-Center is considered a private program. Therefore, when there is a possible threat of inclement weather and/or conditions deemed unsafe for our participants, we have the right to close our programs.

You will be notified of any cancellations regarding the center.

ENROLLMENT REQUIREMENTS

1. The program is available to children diagnosed with autism spectrum disorder(s). Only children whose parents/guardians have completed the registration process may be considered for acceptance into the Center's Saturday Respite Program. The following is required for registration:
 - \$25 Registration Fee
 - Emergency Contact Card
 - Emergency Information Form
 - Tuition Contract
 - \$50 Evaluation Fee (non-SFACS/SFA-Center participants)
2. When the Center's Saturday Respite Program is at maximum capacity, parents may place their child(ren) on a waiting list and be notified on first come, first served basis.

FEES

- **Program Fees are \$100.00 per day**
- Participants must enroll a month in advance.
- Payment for each session must be made in advance.
- There is a registration of \$25 per child. This fee is non-refundable.
- There is a non-refundable evaluation fee of \$50 (non-SFACS/SFA-Center participants)
- Please make checks payable to: **South Florida Autism Center (SFAC)**
- Payment may also be made by credit card (a 3% service fee is added), cashier's check or money order.
- **Based on continuous observational data, some participant's financial requirements may be adjusted by need.**

Payment

SFA Center Saturday Program Respite fees will be collected a month prior to each day as outlined below.

Missed Days / Partial Enrollment

There will be no refunds for days missed.

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Past Due Accounts and Returned Checks

Parents/Guardians will be responsible for restitution on returned checks, including fees and service charges. Only money orders will be accepted until returned checks and fees are paid in full. If payment is not made in full within five (5) days or other arrangements made, the child will be ineligible to attend.

CHILD DROP-OFF/PICK-UP POLICY:

Morning Drop-Off

The Carpool Drop-off area is located at the West E-Library at 7400 W 24th Avenue, Hialeah, FL 33016. Parents are to remain in their car at all times in the drop-off line. Staff will be in front of the building. A staff member will come to your car to collect your child.

After-School Pick Up

A child may only be picked up by people who have been designated on the "Emergency Information Form" by the parent or legal guardian. Please call or send a note to let staff members know that someone other than the parent will pick up the child. Please be sure that the person who will pick up your child knows that he/she will be expected to have an ID, so that we can be sure who is picking up your child. These conditions are made for the protection of your child.

- **Dismissal (3:00 p.m.)**

Staff will be in the parking lot from 2:55pm to 3:00pm. Parents are to remain in cars at all times. Please display the participant information card on the right side of your dashboard. A staff will bring your child to you.

Late Pick-Up Penalty:

If your child is not picked up by 3:00 pm, they will be taken to the library until you arrive. A \$25.00 penalty will be charged after a 5 minute grace period. After 30 minutes you will be charged \$1.00 for every minute thereafter. You will be invoiced for this charge the next day. The City of Hialeah Police Department may be contacted if the child is not picked up in a timely manner.

HEALTH AND MEDICAL INFORMATION:

Allergies

Allergies to foods, chemicals or other environmental issues (such as nuts, pollen, bee stings) must be listed in the "Allergies" section of the child's registration form. Please include any reactions and treatments.

NOTE: WE ARE A NUT FREE CENTER!

Sick Policy:

Parent/Guardians will be called to pick up participants immediately if they appear sick. Signs of illness include, but are not limited to: green mucous, fever, pink eye, diarrhea and vomiting. It is the responsibility of the Parent/Guardian to pick up the participant within a reasonable amount of time. We will make every effort to promptly notify parents in the event of a breakout of contagious illness. For the protection of all the participants, no participant will be admitted to the Center's Saturday Respite Program while he/she has a temperature. We need your help in keeping contagious diseases such as colds and flu out of the center. When your child is sick, you will be called to pick up your child as soon as possible. Participants should not be sent back to the Camp for at least 24 hours after they are clear of fever symptoms. Participants in attendance should be well enough to participate in all activities. Parents must furnish medicine and adhere to the procedures listed below in order for the Staff to administer medications. The parent/guardian must complete a form, which is available in this packet. Staff cannot fill out medicine forms or labels for you.

Medications:

To enable participants to receive their prescribed medications during the teacher work day, a special medication/treatment form must be completed. This form requires the signature of the Doctor prescribing the medication and the parent's signature. Whenever possible, prescription medication should be administered at home. When a physician specifies that medication be administered during the school day, the school should be contacted, and the following guidelines will be used to supervise medication administration in school:

- All medication should be brought to the office at the beginning of the day, **by a responsible adult**, accompanied by a signed and dated Emergency Card, giving the school permission to administer the medication.
- **The medication must be in the original container, with a prescription label** that includes the following information: child's full name, name of medication, prescription number, dosage, and time to be administered.
- Emergency medication will be administered when ordered by the family physician or the school physician.
- Please notify the school of any medication changes. A nurse or trained staff member as designated by the principal distributes medication in all circumstances.
- Participants are not permitted to bring non-prescription medications to school. If during the course of the day, it is necessary for a participant to receive non-prescription medication i.e. Tylenol, a trained staff member will dispense the medication as indicated on the Emergency Card.
- Parents must notify the school of any allergies or restrictions on non-prescription medications.

Registration Information

Please complete the following program application and agreement along with a \$25.00 registration fee. Once complete, return and pay to the Administrator. ***WE MUST RECEIVE PAYMENT AND APPLICATION PRIOR TO THE COMMENCEMENT OF SERVICES.***

**South Florida Autism Center Saturday Respite Program
Emergency Contact Information**

Participant's Name: _____ Name Called: _____

Date of Birth: _____ Present Age: _____ Sex: _____ (H) Phone: _____

Address: _____ City: _____ Zip: _____

*Household Email: _____ (*required)

Mother Name: _____ Occupation: _____ Work Hours: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Father Name: _____ Occupation: _____ Work Hours: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Doctor's name & phone number: _____

Nearest Relative or neighbor to contact in emergency if parents cannot be reached:

Name: _____ (H) Phone: _____ (W) Phone: _____

Name: _____ (H) Phone: _____ (W) Phone: _____

Person authorized to pick up child. (Child can only be picked up by persons on this list)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Additional person living or working in home: (include siblings)

Name & Age Name & Age Name & Age

Allergies _____ Fears _____

Any health problems? _____ Medication required? [] Yes [] No

Medication taken regularly _____

Relate any information which you think would be of help to the staff _____

**South Florida Autism Center Saturday Respite Program
Payment Contract**

This agreement is made on _____ (Date) between South Florida Autism Center, Inc. and the Parent/Guardian, _____, with custody of _____ who reside at the following address:

Address: _____ City: _____ Zip: _____

(H) Phone: _____ (W) Phone: _____ (C) Phone: _____

- I enrolled my child(ren) for the South Florida Autism Center's Saturday Respite Program
- I agree to pay \$100.00 per day.
- I agree to pay a Registration/Evaluation Fee of \$25/50 per each child enrolled in the program. I understand this fee is non-refundable (payment enclosed).
- I do not expect the Center's Saturday Respite Program to provide medical insurance for my child(ren) nor will I hold the South Florida Autism Center's Saturday Respite Program, Director or staff liable for injuries which may occur in the normal provision of child care. I will provide my own medical insurance.
- I have read the attached policies and rules. Until these policies are changed, I accept them as they are and agree to abide by them.

Child(ren) enrolled:

Name & Age

Name & Age

Participant Name: _____

Payment Method:

_____ **I wish to pay by check.** Check Payable to: **South Florida Autism Center, Inc.**

_____ **I wish to pay by credit card:**

Visa _____ Mastercard _____ Amex _____

Card Number: _____

Expiration Date: _____ Security Code: _____

Billing Zip Code: _____

Parent/Guardian Signature: _____ **Date:** _____

Print Name: _____

**South Florida Autism Center Saturday Respite Program
Authorization for Medication**

Date: _____

Participant Name: Last, First _____

Date of Birth _____

Age _____

MEDICATION TREATMENT PLAN TO BE COMPLETED BY PHYSICIAN

Diagnosis: _____

Medication, Dosage, Specific Times and Direction for Administration: _____

Note: Medication must be supplied in the original prescription container. Ask the pharmacist to divide the prescription in two completely labeled containers, one for home and one for camp.

Side Effects/Special Instructions: _____

Note to Physicians: Please complete the Treatment Plan on the next page for participants who require any special health procedures during camp hours (e.g. inhalers, nebulizer treatments, glucose testing, etc.)

Printed Name of Physician _____

Physician's Signature _____

Printed Phone Number _____

Physician's Fax Number _____

PARENTAL PERMISSION

I grant the Director or his/her designee the permission to assist in the administration of each prescribed medication/procedure to be provided during the camp day, including when

Name of Participant _____ is away from camp property on official camp business.

Signature of Parent _____

Date _____

Home Phone/Work/Cell _____

TREATMENT FOR PARTICIPANT NEEDING HEALTH PROCEDURES DURING SCHOOL HOURS

Name of Participant: _____ Age: _____

Treatment Plan: _____

Special Procedures (List special procedures in which participants have been trained; e.g., insulin administration, testing glucose, etc.):

Please list any limitations/precautionary measures that should be considered (e.g. physical education, outdoor activities, transporting, and lifting, special devices/equipment):

Please state any emergency precautions/health emergencies that should be anticipated for this participant (e.g., allergy triggers, diabetic reactions, etc.)

What is the care plan for these identified emergencies? _____

Physician's Signature

Date

**Saturday Respite Program
Participant Photo Release**

I, _____ (Parent Name) and my child _____ (Participant Name), a participant at South Florida Autism Center Inc. Saturday Respite Program, do hereby give permission to use my child's photograph or photographic image in official SFA-Center business, including: SFA-Center web site, SFA-Center newsletters, etc. I understand that photographic or video images will be used for news organizations and promotional purposes.

I hereby waive any right that I may have to inspect or approve the finished product in which a photographic or video image may be used including the advertising copy or other matter that may be used in connection therewith or the use to which it may be applied.

I hereby release, discharge, and agree to save harmless SFA-Center, its officers, employees, attorneys, representatives, and all persons acting under its permission or authority or those for whom acting from any liability by virtue of any blurring, distortion, alteration, optical illusion, or use in composite form whether intentional or otherwise, that may occur or be produced in the taking of said picture or video or in any subsequent processing thereof, as well as any publication thereof, including without limitation any claims for libel or invasion of privacy.

This release contains the entire agreement between the parties and shall be binding upon and inure to benefits of its successors and assigns of the undersigned.

Signed this date _____ / _____ / _____

Participant's Signature

Participant's Printed Name

Parent/Guardian Signature

Parent/Guardian Printed Name

Reservation

Please check the date(s) that you will have your child attend.

- September 23
- October 14
- November 4
- December 9
- February 10
- March 10
- April 21
- May 12

By checking the above box(es) you agree to the payments listed above regardless of circumstances/attendance.

Participant's Name: _____

Parent/Guardian's Name: _____

Parent/Guardian's Signature: _____

Date: _____