

Dunedin Parks & Recreation

Before/After School Program Information

Registration begins at 8 AM on Wednesday, July 16, 2025. Registration must be completed in-person at the Dunedin Community Center or the MLK, Jr. Recreation Center by the Parent or Legal Guardian.

Prerequisites for BASP Registration:

The ePACT profile and any required forms may only be completed by a Parent or Legal Guardian.

All digital and paper forms must be filled out completely with NO BLANK FIELDS.

1. Family Comprehensive Liability Waiver
2. ePACT Network - Medical and Emergency Forms (email invite sent after initial registration)
3. Release for Emergency Care Form (must be notarized)
4. Medication Record Form (If your child requires any type of medication, including non-prescription medications)
5. **Parents of K-5th grade Children must complete** "Promise Time" forms required by the Juvenile Welfare Board; signed by both the Parent/Legal Guardian and Child(ren).
6. **Parents of VPK Children** must submit a copy of their VPK child's current immunization records and health exam before they can register. These may be obtained by your family physician or possibly the school your child will be attending.

Full Time Enrollment & Registration Details:

1. \$25 enrollment fee per child, the first payment, plus any prorated days are due at the time of registration.
2. The annual fee to attend the program is divided into ten (10) monthly payments which are posted to your account on the 20th of each month; advance payments are accepted in-person at any time.
3. **Payments are due by the 1st of each month.** Payments received after the 1st of each month will be charged a \$10 late fee. Children cannot be admitted into the program if the balance due has not been paid by the 3rd of each month.
4. After the initial registration, payments can be made online or during open hours at the centers listed below. **Payments cannot be accepted at the program sites or by phone.**
5. Changes or updates to ePACT or any required form must be made by a legal guardian.
6. Please contact the Registration office for more information at 727-812-4530 or registration@dunedin.gov
7. You may enroll in our Before/After Care program at the Centers below during the hours listed:

Location: Dunedin Community Center
1920 Pinehurst Rd.
Dunedin, FL 34698
727-812-4530

Registration Hours:
Mon –Thurs: 8 AM – 9 PM
Fri: 8 AM – 6 PM
Sat: 7 AM – 4 PM

Location: MLK, Jr. Recreation Center
550 Laura Lane
Dunedin, FL 34698
727-738-2920

Registration Hours:
Mon – Fri: 2 PM – 9 PM
Sat: 10 AM – 7 PM

THIS PAGE INTENTIONALLY LEFT BLANK



Start Date: _____

Program: _____

Site: _____ G: _____

EMERGENCY MEDICAL RELEASE

This form must contain only one child's name, and be the original notarized form.

A new notarized form is required when there is a change in legal guardianship.

Please Print Information**Child's Full Name:** _____ **Birthdate:** _____

Allergies: _____

Medicines Routinely Taken: _____

Name of Custodial Parent(s)/Legal Guardian(s): _____Address: _____
Street Address (number, apartment #, street) City State Zip Code

Home Telephone _____ Cell Telephone _____ Work Telephone _____

Family Physician's Name/Health Care Resource: _____Address: _____
Street Address (number, apartment #, street) City State Zip Code

Telephone () _____

Hospital Preference: _____
Name City**Medical Insurance Company:** _____

Policy #: _____ Expiration Date: _____

Emergency Contact (if custodial parent/guardian cannot be reached): _____Address: _____
Street Address (number, apartment #, street) City, State, Zip Code

Home Telephone _____ Cell Telephone _____ Work Telephone _____

Sign in the presence of the Notary.

I hereby give my consent to any emergency facility and physician to administer necessary treatment to my child

_____, in the event of an emergency at which time
(Child's Full Name)

I cannot be reached. I give consent to transport by ambulance if situation warrants it.

Signature of Custodial Parent/Legal Guardian (Affiant)

STATE OF FLORIDA COUNTY OF _____

The foregoing instrument was acknowledged before me this _____ 20_____
(Month) (Day) (Year)by means of ☐ physical presence or ☐ online notarization by _____ who is personally known
(Name of Affiant)

to me or has produced _____ as identification.

(Type of identification)**SEAL OF NOTARY**Signed: _____ (Signature of Notary)

THIS PAGE INTENTIONALLY LEFT BLANK

BEFORE/AFTER SCHOOL PROGRAM

Below are important policies and guidelines found in the Parent Handbook. Please read carefully before printing and signing your name below to confirm that you agree to adhere to these policies.

- **APPROVED EPACT FORMS, REGISTRATION FEE AND INITIAL PAYMENT ARE REQUIRED** prior to your child(ren) attending. Complete the ePACT form email request(s) and check your email for communication from registration staff and the ePACT network.
- **BILLING:** The balance due for the upcoming cycle is put on your account by the 20th of each month. The billing cycle runs the 1st through the end of the month with payment being due on the 1st. Payment is considered late by the 2nd, and Children can no longer attend beginning on the 3rd. Payments can only be made in person or online.
- **BILLING CHANGES:** Requests to change programs **must be made in writing**, prior to the 20th of each month. Changes will not be made after the month begins. Any change to program enrollment will result in a \$20 admin fee per request. Legal Guardians may transfer once without charge. You must email your request to: registration@dunedin.gov.
- **CANCELATIONS/REFUNDS:** **If your child will no longer attend the program, a written cancellation request is required to stop billing.** No refunds or prorations will be granted after the month begins, medical exceptions may apply. See the Parent Handbook for more information. You must email your request to registration@dunedin.gov.
- **LATE PICK UP FEES:** If your Child is not picked up on time, a late fee will be charged as outlined in the Parent Handbook.
- **SIGN-OUT PROCEDURE:** All changes to the pick-up list must be made in ePACT, including emergency situations. **Phone calls to notify Staff of an alternate pick-up person are not permissible.**
- **ACCURACY:** It is the responsibility of the Parent/Guardian to ensure that their Child's ePACT Medical Record and emergency contact information are accurate and remain up to date. This information can only be entered and updated by a Legal Guardian.
- **TEXT MESSAGE & EMAIL COMMUNICATION:** By providing your email, mobile number and carrier below, you agree to receive notifications about program changes, payments and other relevant information pertaining to activities in which you are enrolled. Message and data rates may apply.
- **Please read the Parent Handbook for all policies & other program information.**

Print Name: _____ **Date:** _____

Signature: _____

Email Address: _____

Mobile Number: _____

Carrier: _____

(Required for Text Messaging)

THIS PAGE INTENTIONALLY LEFT BLANK

**Authorization and Consent for Disclosure,
Receipt, and Use of Confidential Information
by the Juvenile Welfare Board of Pinellas County**

I, _____ (print participant name(s))
acknowledge that I am a participant of _____ (name of
program or service). I acknowledge that the Juvenile Welfare Board of Pinellas County ("JWB")
provides funds to make the program or service in which I am participating available. I also
acknowledge that in order to make sure that all services delivered to participants are of the
highest possible quality, JWB may need to review information about me and these services.

By signing this Authorization, I am indicating that I understand and agree that my confidential information may be contained in a JWB data collection system, and that this data collection system is exempt from disclosure under the Florida Public Records Act. This means that by law, JWB cannot release individually identifiable information about me or the services I receive (Fla. Stat. §119.071). I acknowledge that as necessary to carry out the purposes listed herein, JWB may review all information about me, including my participant file and all other information pertaining to me held by the agency providing the program or service, regardless of whether that information is entered into a JWB data collection system. I further acknowledge that JWB is simply storing and reviewing records and information as the payor for these services, and that JWB generally provides no direct services to me, except in certain circumstances may facilitate service delivery I further acknowledge that JWB does not provide medical diagnoses to me and JWB is not a covered entity as that term is defined under HIPAA (the Health Insurance Portability and Accountability Act).

I authorize JWB to utilize my confidential information to verify eligibility for funded services or programs, to facilitate service delivery, make payment for services rendered to me by funded programs or services, quality control of funded services or programs, evidence-based research of JWB funded services or programs, including, but not limited to, tracking outcomes of funded programs and services, and determination of future services/programs funded by JWB. I understand that the confidential information disclosed, received or used by JWB related to my Authorization will not be further disclosed to any other party without my express written consent or as otherwise permitted or required by applicable law unless it is presented in a report that presents information on a group of individuals in de-identified format, which means that no information that identifies me as an individual is revealed.

I acknowledge that this Authorization covers all information about me including, but not limited to, personally identifiable information, Protected Health Information, general medical, general counseling, as well as psychiatric/ psychological/ substance abuse information from my medical health record, any information concerning the performance of any tests, results of those tests, and counseling and treatment records, as allowed by all state, federal and local laws, including, but not

limited to the following: Florida Statutes 394.459, 381.004, and 395.3025; Florida Evidence Code 90.503, 90.5035, and 90.5036; HIPAA, and the Code of Federal Regulations (CFR) Title 42. I consent to my minor participating in online or paper surveys that will be used for program improvements and enhancements. I understand that my records have a privileged and confidential status. I am waiving that status for the purposes contained by this Authorization.

I understand that the confidential information disclosed, received or used by JWB based on this Authorization will not be further disclosed to any other party without my express written consent or as otherwise permitted or required by applicable law. However, the individually identifiable confidential information received by JWB based on this Authorization may be used by JWB and its agents for research purposes, so long as the research results are reported as a whole in de-identified format, which means that no information that identifies me as an individual is revealed. Except, JWB will not provide any records covered by CFR Title 42 to any JWB agents.

I understand that I have the right to withdraw my approval in writing at any time. However, it is possible that JWB may have already relied on this Authorization before it receives notice of my withdrawal and that JWB may have already taken action based on the Authorization. If I do not withdraw my approval, it will automatically end one (1) year from the last day I received services from this program, or with respect to information used in research, or for compliance and quality review activities performed by JWB or its agents, upon completion of the last research project or compliance/ quality review, whatever occurs latest. By my signature below, I acknowledge that I have given my consent as indicated above freely, voluntarily, and without coercion, and that I have been given a copy of this authorization, signed by me on the date shown below.

 Witness Signature

 Date

 (print participant name)

 Effective Date

 Signature of Participant or Participant's
 Authorized Representative (check one):

- ☐ Participant ☐ Parent ☐ Guardian
☐ Personal Representative (Legal Documents
 Required)

**Site: Dunedin Parks & Recreation
 Promise Time
 Participant and Parent/Guardian
 Statement of Commitment**

The Promise Time initiative is a learning center program for students that offers a variety of stimulating activities to promote school success and personal well-being in a safe environment. **Active attendance and engagement are essential to the students' progress and program's success.**

I understand the activities of the Promise Time program include:

- Youth will complete pre- and post-assessments to monitor their progress and help in the youth's curriculum plan.
- Youth will participate in tutoring and online activities to improve in their academics.
- Youth will participate in programming related to project-based learning activities with an emphasis on reading, science and/or math skills, as provided.

I have read and understand the activities listed above.

_____	_____
(Parent or Guardian Signature)	Date
_____	_____
(Youth Signature)	Date

REQUIRED

This section is to be completed by parent or guardian and center director or supervisor in charge of Promise Time

I, _____ parent/guardian of _____ give my permission for the

(Print parent/guardian name) (Print youth name)

staff of this OST program, located at this school, to share my child's enrollment in this OST program with the schools. I also agree to all the staff of this OST program, located at this school, to review my child's academic and behavior progress reports or their report cards in order to document growth and progress in my child during his/her time in this program. This includes information about whether my child has an identified exceptionality, an Individual Education Plan or Academic Improvement Plan, and suggestions from my child's teacher(s) on how my child can best be helped in the program.

_____	_____	_____	_____
Parent/Guardian Signature	Date	Director Signature	Date