WYALUSING ACTION (21ST CCLC) Afterschool Program Enrollment Form (Fall 2019–Spring 2020)

Child's Name: _______________________________ Date of Birth: ___/___/____ Grade: ______

Mailing Address: Gender: ____ Male ____ Female

____

____

____

____

Racial/Ethnic Group (circle all that apply)
American Indian/Alaska Native Asian
Black or African American White
Hispanic or Latino Other
Pacific Islander

My child will attend program on: (all four days are expected with exception to previously scheduled programs and appointments) (check all that apply)
___ Monday ___Tuesday ___Wednesday ___Thursday

CONSENT

I give my child permission to participate in the 21st Century Community Learning Centers' Afterschool program at Wyalusing Area School District.

PARENT/GUARDIAN SIGNATURE_____________________________________
Date:______________________

Parent/Guardian #1 (Primary Contact)

Name: ____ Relationship to Student: ______________________________________

Mailing Address: _________________________________ Home Phone: ______________________________________

_________________________________ Cell Phone: ______________________________________

_________________________________ Work Phone: ______________________________________

Email Address: _________________________________ Language(s) Spoken: ______________________________________

Parent/Guardian #2 (Primary Contact)

Name: ____ Relationship to Student: ______________________________________

Mailing Address: _________________________________ Home Phone: ______________________________________

_________________________________ Cell Phone: ______________________________________

_________________________________ Work Phone: ______________________________________

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Email Address: ______________________________ Language(s) Spoken: __________________________________

TRANSPORTATION AUTHORIZATION

The Afterschool program will be offering transportation home upon dismissal from the program.

My Child will: ____ Take the bus ____ Be picked up from program by parent/guardian

Bussing Address (if different from mailing address): ____

The following individuals have permission to pick up my child:

Priority	Name	Relationship to Child	Cell Phone	Phone #2
1st				
2nd				
3rd				

I, __________________________________, understand and give permission to Wyalusing ACTION 21st CCLC Staff to release my child, _________________________________, to the individuals listed above. If for any reason my child must be picked up from the program (i.e. illness, suspension, etc.) the afterschool staff may contact any of the persons listed above as having permission to transport my child.

____ ________________________

Parent/Guardian Signature Date

EMERGENCY MEDICAL TRANSPORTATION

In the event of illness or an accident requiring immediate medical care permission is granted for emergency medical transportation and treatment. I, ____________________________, give permission to the afterschool staff to call 911 and arrange transportation of my child to/from the closest medical facility, hospital or Physician's office.

_________________________________ ______________

Parent/Guardian Signature Date

Hospital Preference: ______________________________

Pediatrician/Family Physician: _______________________ Phone Number (____) _____________________

It is understood that every effort will be made to contact the parent and/or guardian promptly, however, in an emergency situation where a parent and/or guardian cannot be reached, please contact the following:

Contact 1

Name: ______________________________

Address: ____________________________

Contact 2

Name: ______________________________

Address: ____________________________

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Phone: (_____) _________________________ Phone: (_____) _________________________

HEALTH INFORMATION

This confidential health information will only be used to ensure the safety of the children in this program. Please provide your child's medical history (if yes, please specify)

Allergies to food: Yes ___ No ___ Specify ____

Behavioral/Emotional Yes ___ No ___ Specify ____

Physical Disabilities: Yes ___ No ___ Specify ____

Corrective Devices: Yes ___ No ___ Specify ____

Asthma: Yes ___ No ___ Does your child use an inhaler: Yes ____ No ____

Allergies to penicillin: Yes ___ No ___ Allergy to plants: Yes ____ No ____

Allergy to insect stings: Yes ___ No ___ Hay Fever: Yes ____ No ____

Convulsions/seizures: Yes ___ No ___ Diabetes: Yes ____ No ____

Learning Disability: Yes ___ No ___

Other ____

Does your child have special health care needs that require treatment and/or medication? Yes ____ No _____

If Yes to any of the above, please give us any detail that will help us provide *prompt Care & proper Educational service*. Remember that the Sayre Nurses' office is NOT open after school so other arrangements have to be in place through us.

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PERMISSIONS

Child's Name: ______________________________ School: ______________________________

Consent to Photograph, File, or Videotape a Student for Non-Profit Use (Educational, Public Service or Health Awareness Purposes)

________ I hereby consent to the participation in interviews, the use of quotes, and the taking of photographs, movie or video tapes of the Student named above by **Wyalusing ACTION 21st CCLC Afterschool Program**.

________ I also grant to **Wyalusing ACTION 21st CCLC Afterschool Program** the right to edit, use, and reuse said products for non-profit purposes including use in print, on the internet, and all other forms of media.

________ I also hereby release to **Wyalusing ACTION 21st CCLC Afterschool Program** and its agents and employees from all claims, demands, and liabilities whatsoever in connection with the above.

Student Data and Evaluation Consent Form – (Only used TO IMPROVE our program)

In order to monitor the effectiveness of the afterschool program and its future success, an independent evaluator is conducting an ongoing evaluation. It is the intention of the evaluation to learn how these after-school services help students, and how they can be improved in order to meet the grant requirements.

Specifically, the CBO **Tricia Tietjen** and the Evaluator, **Laura Payne-Bourcy** asks permission to:

- Contact your child's school to obtain records showing his or her progress, including information about grades and citywide and statewide test scores.
- Survey and/or interview you and your child about the afterschool program and its effects. Any information we collect will be used only to assess the after-school program and **will NOT be made public.** Participating in the evaluation **will NOT affect your child in school or in the afterschool program,** or in any other way. We will NOT use your name or your child's name in any report. At the end of the evaluation, we will destroy all records that include personal information. Participation in the study is completely voluntary and participants may withdraw at any time with no consequences. Please select one of the options below.

_______ YES, I GIVE PERMISSION FOR MY CHILD TO PARTICIPATE. I have read the above information and I give permission for my child to participate in the evaluation of the afterschool program. I also consent for the evaluator and the CBO to obtain my child's records (IEP, progress reports, report cards) and to interview me and my child if I wish at that time.

________ NO, I DO NOT WANT MY CHILD TO PARTICIPATE, I have read the above information and I DO NOT give permission for my child to participate in the evaluation of the afterschool program.

If at any time you change your mind about this decision, you may contact the Program Director.

I have read and understand all of the Afterschool Program permissions, I reviewed them with my child and agree to abide them.

Parent/Guardian Signature ______________________________ Date ____________________________