

| PowerUP! After School registration form | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- |
| student Information | | | | | | | |
| Full Name: | | | | | | | |
| Date of birth: | Gender: | | | | | | Grade: |
| School: (Please Circle) Dewey Field Central Bishop Hogan | | | | | | | |
| Parent/guardian Information | | | | | | | |
| Parent/Guardian Name(s): | | | | | | | |
| Address: | | | | | | | |
| City: | State: | | | | | | Zip Code: |
| Home Phone: | Cell Phone: | | | | | | Work Phone: |
| Email: | | | | Relationship to Student: | | | |
| Emergency Contact information | | | | | | | |
| Emergency Contact Name: | | | | | Relationship: | | |
| Home Phone: | | | | | Work/Cell Phone: | | |
| Emergency Contact Name: | | | | | Relationship: | | |
| Home Phone: | | | | | Work/Cell Phone: | | |
| Student medical information | | | | | | | |
| Primary Care Physician: | | | | | | Phone: | |
| Medical Care Facility/Hospital: | | | | | | Phone: | |
| Medications: | | | Allergies: | | | | |
| Please list any additional medical information (diet, ADD/ADHD, asthma, etc.): | | | | | | | |
|  | | | | | | | |
| Student transportation information | | | | | | | |
| Please indicate how your child will get home from the After School Program: | | | | | | | |
| □ My child will walk/ride bike home | | | | | | | |
| □ My child will be picked up | | | | | | | |
| Persons Authorized to Pick UP Student | | | | | | | |
| Name: | | Relationship: | | | | | |
| Name: | | Relationship: | | | | | |
| Name: | | Relationship: | | | | | |
| media/photo release | | | | | | | |
| □ I give permission for my child to be photographed or videotaped as part of his/her involvement in the NMCYF PowerUP! After School Program. I also give permission for his/her photo and/or image to be used in publications and/or promotional material associated with the after school program.  □ I do NOT give permission for my child to be photographed or videotaped as part of his/her involvement in the NMCYF PowerUP! After School Program. I also do NOT give permission for his/her photo and/or image to be used in publications and/or promotional material associated with the after school program. | | | | | | | |
| Signature of Parent/Guardian: | | | | | | | Date: |

| PowerUP! After School registration form | | |
| --- | --- | --- |
| parent responsibility contract | | |
| Parent/Guardian Initials |  | |
|  | I, the undersigned, certify that my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, has my permission to take part in the program conducted by NMCYF. In consideration of the acceptance and enrollment of my child in the program, I do hereby expressly waive any claim for injuries sustained by said child participating in the program. | |
|  | I understand that this is a well-child program. I will not send my child to the program if they are ill. My child is not eligible to attend the program if they did not attend school that day. | |
|  | I understand that the PowerUP! After School Program promotes healthy lifestyles. I will not send my child to the program with clothing or gear reflecting inappropriate messages regarding smoking, drinking, sexuality, etc. | |
|  | I understand that this program follows the Chillicothe R-2 School District calendars. | |
|  | I will take all steps necessary to ensure that any/all individuals authorized to pick up my child will be drug/alcohol free and will conduct themselves in a courteous/respectful manner when they arrive on site. | |
|  | I realize that picking up my child by 6:00 pm is an important responsibility on my part and that failing to do so will result in the following procedures:  -A $5.00 fee per child will be assessed for every 15 minutes a child remains at the program past 6:00 pm (ex. 6:01-6:15 pm=$5.00 per child, 6:16-6:30 pm=$10.00 per child).  -The first and second time this occurs, I will be informed that failing to pick up my child on time may result in my child’s loss of program services.  -The third time this occurs, I will receive written notification that my child will no longer be able to participate in the program. | |
| Program payment agreement policy | | |
|  | Payments are due on or before the 1st of the month preceding services. | |
|  | Any payments received after the 1st of the month will incur a $15 late charge. | |
|  | **If payment due remains unpaid by the last day of the month in which it is due, parent/guardian agrees to withdraw the child from the program as of the first day of the following month.** | |
|  | A child who is withdrawn from the program for non-payment can re-register for services (if space is available) by paying:   1. An additional $15 registration fee; 2. Payment for all days of service to be used within that month prior to the first day of attendance and 3. Payment of any/all outstanding balances due or previous service. | |
| refund policy | | |
| No refunds will be given for program(s). | | |
|  | | |
| I, the undersigned, have read, understand and accept the conditions by which I must abide and which are contained in the Parental Responsibility Contract. Failure to comply may result in loss of program privileges. | | |
| Signature of Parent/Guardian: | | Date: |

MEDICAL RELEASE FORM

Does your child take any medications that will need to be administered during program hours?

If yes, please list medication, dosage and time to be given \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Parent/Guardian Name), hereby give permission for any and all medical attention to be administered to my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Child’s Name) in the event of accident, injury, sickness, etc., under the direction of the person(s) listed below, until such time as I may be contacted. If necessary, I approve of officials taking my child to the nearest doctor or hospital. If I cannot be reached by phone, such medical treatment, including surgery, as deemed necessary by competent medical personnel, would be rendered. I also assume the responsibility for the payment of any such treatment. This release is effective for the period of one year from the date given below.

ADDRESS:

INSURANCE COMPANY:

POLICY NUMBER:

In case I cannot be reached, any of the following persons is designated to act on my behalf:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please attach a copy of your child’s current immunization records.