

# 2022-23 After School Program Registration

<b>STUDENT INFORMATION</b>	School: _____		<b>Reason for enrolling / Days child will attend Program:</b> <input type="checkbox"/> Teacher Referral <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Academic Help <input type="checkbox"/> Wed <input type="checkbox"/> Thur <input type="checkbox"/> Work Schedule <input type="checkbox"/> Fri <input type="checkbox"/> Other: _____	
	Last Name _____ First Name _____			
	Grade _____ Birthdate _____ Teacher's Name _____			
	<b>PRIMARY (Parent/Guardian):</b>			

<b>PARENT/ GUARDIAN INFORMATION</b>	Name: _____		Name: _____	
	Relationship: _____		Relationship: _____	
	Address: _____		Address: _____	
	Primary Phone: _____		Primary Phone: _____	
	Place of Employment: _____		Place of Employment: _____	
	Work Phone: _____		Work Phone: _____	
	E-Mail: _____		E-Mail: _____	
	<input type="checkbox"/> Child Lives at this address		<input type="checkbox"/> Child lives at this address	

<b>EMERGENCY CONTACTS</b>	<i>List other people authorized to pick up your child from program (Must be 14 or older and have identification):</i>		
	Name: _____	Name: _____	Name: _____
	Phone: _____	Phone: _____	Phone: _____
	Relationship: _____	Relationship: _____	Relationship: _____
	<input type="checkbox"/> I authorize all individuals listed on the school emergency card for pick up		

<b>MEDICAL INFORMATION</b>	<b>Check (x) any special medical condition that your child might have.</b>		<input type="checkbox"/> Epi-pen for allergies
	<input type="checkbox"/> Food allergies		<input type="checkbox"/> Inhaler for allergies
	<input type="checkbox"/> Non-food allergies		<input type="checkbox"/> Inhaler for Asthma
	Specify: _____		<input type="checkbox"/> Epilepsy/Seizure disorder
			<input type="checkbox"/> Diabetes
Other special/medical needs OR signs/symptoms to watch for medical conditions. Specify: _____			
Doctor Name: _____		Phone Number: _____	
<input type="checkbox"/> Yes <input type="checkbox"/> No <b>Will your child require medication at program?</b> If medications are necessary, a copy of the "Authorization to Administer Medication" form should be attached to this form.			

<b>OTHER</b>	Does your child have an IEP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Primary language of student? _____	Ethnicity: _____
	Primary language of the parent/guardian? _____	
	Special concerns about your child or family - Specify? _____	

<b>AUTHORIZATION</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	I hereby give my consent for my child to receive emergency medical care or treatment if I cannot be reached immediately.
	<input type="checkbox"/> Yes <input type="checkbox"/> No	I will review the policies of this program and the guidelines by which the program is run and understand that it is my responsibility to assure that my child is present until the conclusion of any program day attended.
	<input type="checkbox"/> Yes <input type="checkbox"/> No	I give my child permission to participate in fieldtrips and other off-site activities during program hours and that I will be notified in advance of these opportunities.
	<input type="checkbox"/> Yes <input type="checkbox"/> No	I give my permission for my child to be photographed or videotaped for newsletters, website, and brochures.
	<input type="checkbox"/> Yes <input type="checkbox"/> No	I give my child permission to participate in anonymous and/or confidential surveys and data for grants.

The number of eligible children seeking to enroll in the After School program often exceeds the number that may be safely & effectively served with available funding; therefore waiting lists may sometimes be established. Preference will be given to students who meet the grant criteria and attend program 5 days a week for the entire daily length of the program. Lack of transportation will not be a barrier to participation; contact Extended Learning at (920) 448-3578 regarding an application for transportation assistance.

**Signature of Parent/Guardian** \_\_\_\_\_

Relationship:     Mother     Father     Other \_\_\_\_\_      Date: \_\_\_\_\_

Office Use Only:	
Start Date: _____	Start Date: _____
End Date: _____	End Date: _____