Registration fee $50.00
Paid _____ Type of Payment: ______
Date: ___________________________

SCHOOL:

AFTERSCHOOL CLASSÉ

REGISTRATION INFORMATION

(PLEASE PRINT AND COMPLETE ALL INFORMATION REQUESTED)

Date: ___________________________

Child's Legal Name (Last, First) ____ Called by _________________________

Birthdate_____________________________ Sex: ( ) Female ( ) Male

Home Address____ City ____
Street Address

State _____________ Zip________________ County ______________ Home Phone # ______________________________

Parent/Guardian Name____ Social Security # _____________________________
(If different from above)

Home Address____
Street Address City State Zip

Home Phone #______________________________ Cell Phone #_______________________________

Place of Employment ____ Business Phone # ___________________________

Business Address____

Email Address: ____

Parent/Guardian Name____ Social Security # ____________________________

Home Address____
(If different from above) Street Address City State Zip

Home Phone #______________________________

Place of Employment ____ Business Phone __________________________

Business Address____ Cell Phone #_____________________________

Email Address: ____

Child Living Arrangements: [ ] Both Parents [ ] Mother [ ] Father [ ] Other: ________________________________

Parent's Marital Status [ ] Married [ ] Single [ ] Divorced

If divorced who has legal custody? ____

May the non-custodial parent pick the child up? [ ] YES [ ] NO

Non-custodial parent name: ____

Name______________________________
Age__________

(PLEASE PRINT AND COMPLETE ALL INFORMATION REQUESTED)

In the event of an emergency, one may contact the following: (Please list emergency contacts below.) Please note: if you are unable to pick up your child/children, he/she/they will be released only to the persons listed here as well.

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: ____ Relationship to Child: _______________

Phone: (________) ___________________ Preferred contact # (________) ___________________

E-mail: ____

Home Address: ____
(If different from above) Street Address City State Zip

Second parent/guardian or other emergency contact:

Name: ____ Relationship to Child: _______________

Phones: (________) ___________________ Preferred contact # (________) _______________________

E-mail: ____

Home Address: ____
(If different from above) Street Address

Additional contacts in event parent(s)/guardian(s) cannot be reached:

- Name: ____ Relationship to Child: __________

  Phones: (________) ___________________ Preferred contact # (________) ________________

  Home Address: ____

  E-mail: ____

- Name: ____ Relationship to Child: ___________

  Phones: (________) ___________________ Preferred contact # (________) _________________

  Home Address: ____

  E-mail: ____

Note: Persons that the staff is not familiar with will only be allowed to pick up your student if you have sent written permission beforehand and/or called the Site Director to make special arrangements. This person must show valid identification to pick up your student.

Name_______________________________
Age__________

PARTICIPANT HEALTH HISTORY

(PLEASE PRINT AND COMPLETE ALL INFORMATION REQUESTED)

THIS SECTION MUST BE FILLED OUT COMPLETELY (Please list local doctors only.)

Child's Physician____Phone #________________________

Address ____

Hospital Preference____
(Please note: If preference is not the closest emergency health care facility; ASC will use the closest emergency facility to expedite care for the student.)

Name of child's dentist(s): ____ Phone: (_____) _______________

Allergies: ☐ No known allergies

This child is allergic to ☐ Food ☐ Medicine ☐ Environment (insect stings, hay fever, etc.) ☐ Other
Please describe below or on the additional sheet what the student is allergic to and the reaction seen.)

Diet, Nutrition: ☐ This child eats a regular diet. ☐ This child eats a vegetarian diet.
☐ This child has special food needs. (Please describe below or on an additional sheet.)

Immunizations: Are your immunizations current for school? ☐ Yes ☐ No

If your child has not been fully immunized, please sign the following statement
I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian _________________________ Date: _______________
Relationship to Child: __________________________

Please supply a copy of your child's immunization record.

Copy submitted and attached [ ] YES [ ] NO Parent contacted about immunization record: _________ by: __________
Date initials

Date received: ________________

Medication: **AFTERSCHOOL CLASSES DOES NOT ADMINISTER MEDICATIONS.**

☐ This student will not take any daily medications while attending the ASC program.

Medical Insurance Information:
This child is covered by family medical/hospital insurance ☐ Yes ☐ No

Insurance Company _________________________________ Policy # ________________________
Subscriber ____________________________________ Insurance Co. Ph. No. (____) _____________

PARTICIPANT HEALTH HISTORY (CONTD)

Restrictions:

- ☐ Outside play and activities - I feel the child can participate without restriction.
- ☐ I feel the student can participate with the following restrictions or adaptations. (Please describe below or on a separate sheet.)

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below. Has/does the child:

1. Ever been hospitalized? ☐ Yes ☐ No	9. Had fainting or dizziness? ☐ Yes ☐ No
2. Ever had surgery? ☐ Yes ☐ No	10. If female, have problems during menstruation? ☐ Yes ☐ No
3. Have recurrent/chronic illness? ☐ Yes ☐ No	11. Ever had back/joint problems? ☐ Yes ☐ No
4. Had a recent infectious disease? ☐ Yes ☐ No	12. Have problems with diarrhea/constipation? ☐ Yes ☐ No
5. Had a recent injury? ☐ Yes ☐ No	13. Have any skin problems? ☐ Yes ☐ No
6. Had asthma/wheezing/shortness of breath? ☐ Yes ☐ No	14. Passed out/had chest pain during exercise? ☐ Yes ☐ No
7. Have diabetes? ☐ Yes ☐ No	15. Traveled outside the country in the past 9 months? ☐ Yes ☐ No
8. Had seizures? ☐ Yes ☐ No	16. Had mononucleosis ("mono") during the past 12 months? ☐ Yes ☐ No
9. Had headaches? ☐ Yes ☐ No	18. Wear glasses, contacts, or protective eyewear? ☐ Yes ☐ No

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.
Has the child:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ☐ Yes ☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? ☐ Yes ☐ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? ☐ Yes ☐ No
4. Had a significant life event that continues to affect the child's life? ☐ Yes ☐ No

Please explain "Yes" answers in the space below or on an attached sheet, noting the number of the questions. ASC may contact you for additional information.

EMERGENCY MEDICAL AUTHORIZATION

Parent/Guardian Authorization for Health Care:
This health history is correct and accurately reflects the health status of the child to whom it pertains. The person described has permission to participate in all activities for the registered program except as noted by me and or an examining physician. I give permission to the physician selected by AfterSchool CLASSÉ to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with the camp staff. I give permission to photocopy this form. Also, the program has permission to obtain a copy of my child's health record from providers who treat my child, and these providers may talk with the program's staff about my child's health status.

Signature of Custodian
Parent/Legal Guardian ______________________________________ Date: _________ Relationship to student: ___________

PARENTAL AGREEMENT WITH AFTERSCHOOL CLASSÉ

1. The AfterSchool CLASSÉ (ASC) agrees to provide after school care for ____________________ (name child is called) from Monday through Friday, 2:30 p.m. to 6:30 p.m. (Except scheduled holidays and closings.) My child will participate in the following meal plan - afternoon snack.
2. My child will not be allowed to enter or leave the facility without being escorted by the parent(s), a person authorized by the parent(s), or facility personnel.
3. Medication will not be administered in After School Program. If your child must have medication, please make arrangements for it to be administered during regular school hours by school nurse/medical personnel.
4. I acknowledge that it is my responsibility to keep my child's records current to reflect any significant changes as they occur, e.g. telephone numbers, work locations, emergency contacts, child's physician, child's health status.
5. The facility agrees to inform me of any incidents, including illnesses, injuries, and exposure to communicable diseases; which includes my child.
6. The ASC agrees to obtain written authorization from me before my child participates in routine transportation, field trips, special activities away from the facility, and water-related activities occurring in water that is more than two (2) feet deep.
7. I agree to abide by the policies and procedures for AfterSchool CLASSÉ Program.

____ ____________________

Signature (Parent/Legal Guardian) Date

____ ____________________

Signature (Facility Administrator) Date

AfterSchool CLASSÉ

MEDIA RELEASE FORM

I hereby consent to my child's name, likeness, picture or voice to be used by AfterSchool CLASSÉ or the news media. I am aware that my child may be asked a variety of questions (under the supervision of an adult) and the contents of the interview may be published or aired for public view. I understand that my child will be under the supervision of an AfterSchool CLASSÉ staff member during the interview or photo session. Additionally, my child has the right to terminate the interview, photo or video session at any time.

I hereby hold harmless and waive all claims against AfterSchool CLASSÉ or its agents on any liability for the use of my child's name, likeness, picture, and or voice, and against any claim arising out of my child's acts or statements during the interview, photography session or program. Further, I release AfterSchool CLASSÉ, its agents, and employees from any claim which I may assert in the future, arising out of AfterSchool CLASSÉ publications and its use of the information given and any photograph taken.

PARENT'S/GUARDIAN'S SIGNATURE_______________________ DATE_______

CHILD'S NAME___________________________________

STAFF SIGNATURE______________________________ DATE_______

AfterSchool CLASSÉ
6411 El Caudillo Court
Atlanta, GA 30349
770-964-4487

HH: __________

ML: __________

SP: __________

2017-18 ASC Parent Authorization Form

Date: ______________________

Child's Name: ____

Parent/Guardian Name: ______________________ Signature: ______________________

Phone Number: ______________________ 2nd Contact # ______________________

Parent/Guardian Name: ______________________ Signature: ______________________

Phone Number: ______________________ 2nd Contact # ______________________

Please use the following e-mail address for our family updates:

____

I authorize the following person(s) to pick up my child from After School CLASSE program and/or in the event of an emergencý:

AUTHORIZED PERSON:	ADDRESS:	RELATIONS TO STUDENT:	CONTACT NUMBER:

STAFF USE ONLY: FT: ____________ PT: ______________________ DI: _________________