

Registration fee \$50.00
Paid _____
Date _____



SCHOOL: _____

AFTERSCHOOL CLASSE

REGISTRATION INFORMATION

(PLEASE PRINT AND COMPLETE ALL INFORMATION REQUESTED)

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

Birthdate _____

Sex: () Female () Male

Home Address _____

Street Address City State Zip

State _____ Zip _____ County _____ Home Phone # _____

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 # _____

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 # _____

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: _____

Phones: (_____) _____ 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 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 CLASSÉ 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. (____) _____

Name _____
Age _____

PARTICIPANT HEALTH HISTORY (CON'T)

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



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: _____

I authorize the following person(s) to pick up my child from After School Classe:

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

I authorize the following person(s) to pick up my child IN THE EVENT OF AN EMERGENCY from After School Classe:

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

STAFF USE ONLY: FT: _____ PT: _____ DI: _____