

Confidential

AFTER SCHOOL PROGRAM APPLICATION

Confidential

Student Name (Last, First)	Grade	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate
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Please answer the following:

Ethnicity: Is your son/daughter Hispanic or Latino? (Select only one)

- No, not Hispanic or Latino
- Yes, Hispanic or Latino

The above part of the question is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one or more of the boxes to indicate what you consider your son/daughter's race to be: (Select one or more)

- | | | |
|---|------------------------------------|--------------------------------------|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Guamanian | <input type="checkbox"/> Other Asian |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Hawaiian | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Hmong | <input type="checkbox"/> Tahitian |
| <input type="checkbox"/> Cambodian | <input type="checkbox"/> Japanese | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Korean | <input type="checkbox"/> White |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Laotian | |

My son/daughter will:

- Be picked up every day at _____ p.m. (After School Program dismissal time)

PARENT/GUARDIAN SECTION

NOTE TO PARENT/GUARDIAN: By signing below, I give my son/daughter permission to attend the After School Program beginning at the conclusion of the regular school day until the Program's dismissal time. I am aware my son/daughter **must** be picked up by the dismissal time stated above or have an Early Release Form on file. I understand anyone picking up my son/daughter may be required to provide identification to the After School Program staff. If further clarification is needed, the After School Program staff may contact me, the parent/guardian, at the phone number below.

Parent/Guardian Name	Date
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Address

Home Phone	Work Phone	Cell Phone
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Sign-Out Waiver: I allow my son/daughter to be signed-out from the Program by the following individuals:

Name	Relationship	Phone Number

Media Release

By signing below, I give permission for my son/daughter to be interviewed, photographed, and/or videotaped while participating in the After School Program. I am aware there are times the Program may be featured in news stories and reporters, photographers, and/or film crews from television, radio stations, and newspapers may wish to interview my son/daughter. I understand that such photographs, video recordings, and/or reports will be property of the After School Program, its respective school district, and California Teaching Fellows Foundation, and may be used **ONLY** for the purpose of documenting or publicizing the After School Program through print, web, and social media.

By signing below, I acknowledge I have read the After School Program attendance guidelines. I understand my son/daughter must follow these guidelines in order to participate in the After School Program.

Parent/Guardian Signature	Date	Phone Number
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STUDENT EMERGENCY CONTACT FORM/MEDICAL CONSENT

In case of an emergency, it is imperative that the After School Program be able to reach the student's parent or guardian. Please fill in the information on both sides of this form carefully and accurately. Please type or use ink and print clearly and legibly.

STUDENT

Last Name _____ First Name _____ Middle _____

Lives with: Both Parents Mother Father Legal Guardian

Address change? YES NO If Yes, please contact your after school office.

MOTHER/GUARDIAN

Last Name _____ First Name _____ Email _____ Employer _____

Home Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

FATHER/GUARDIAN

Last Name _____ First Name _____ Email _____ Employer _____

Home Address (if different from Mother/Guardian) _____ City _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Is there any COURT-MANDATED custody/visitation orders limiting access to this student?

YES NO If Yes, please attach legal order.

If your child requires medication at school, all medication sent to school must be in the original prescription container with a current date and the child's name.

MEDICATION

DOSAGE

HOUR(S) GIVEN

MEDICATION	DOSAGE	HOUR(S) GIVEN

HEALTH INSURANCE INFORMATION

California Kids Family Health Insurance Healthy Families Medi-Cal # _____ No Health Insurance

Health Plan Group Name _____ Policy Number _____

Primary Physician/Health Care Provider _____ Phone Number _____

MEDICAL CONDITIONS

Wears glasses/contacts for board work for reading all the time Date of last eye exam _____ Wears hearing aid(s) Diabetes Insulin dependent Yes No

Severe allergies requiring Epi-pen Benadryl Please explain type of allergy _____

Current Asthma If checked: uses inhaler on daily medication Current seizures If checked: on medication

Please explain any recent illnesses, hospitalization, surgery or any medical condition which might require accommodation at school _____

I/we, the undersigned parent(s) or legal guardian of _____, a minor, do hereby give authorization and consent to the Before School/After School Program to obtain emergency medical care and necessary transportation, including x-ray examination, anesthetic, medical or surgical diagnosis and emergency hospital which is deemed advisable by and is to be rendered under the general or specific supervision of medical and emergency room staff licensed under the provisions of the medicine practice act and the State of California Department of Public Health. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the student, but that any of the above treatment will not be withheld if the undersigned or authorized adults cannot be reached.

_____ is the hospital I/we prefer for emergency medical treatment of my/our child.

I/we understand that the school district does not provide accident/medical insurance for students, and I/we further understand that all costs related to medical treatment may be my/our responsibility and not that of the school district.

I declare that the information on this form is true and correct. I will notify the After School Site Lead immediately of any changes to be made in the foregoing information.

Parent/Guardian Signature _____ Date _____ Phone Number _____