

CITY CONNECTIONS PROJECT | STUDENT REGISTRATION FORM

PLEASE READ CAREFULLY AND PRINT CLEARLY.
THIS REGISTRATION FORM MUST BE COMPLETED IN ITS ENTIRETY.

SECTION I SITE OFFICE USE ONLY					
ORGANIZATION				COUNCIL DISTRICT	
PROJECT SITE				SCHOOL DISTRICT SERVED	
DATE OF ADMISSION				DATE OF WITHDRAWAL	
SECTION II STUDENT INFORMATION					
List all children enrolling in the CASE for Kids City Connections after-school program.					
Name (Last, First)	DOB (mm/dd/yy)	Grade	Gender (M/F)	Race (Black/African-American, White, Asian, Native American, Pacific Islander, Other)	Ethnicity (Hispanic or Non-Hispanic)
SECTION III HEALTH INFORMATION					
Please complete this section for each child listed above.					
Name (Last, First)	Medications	Allergies	Health Problems	Participate in Recreational Activities?	
				<input type="checkbox"/> YES	<input type="checkbox"/> NO
				<input type="checkbox"/> YES	<input type="checkbox"/> NO
				<input type="checkbox"/> YES	<input type="checkbox"/> NO
SECTION IV PARENT/GUARDIAN INFORMATION					
Parent/Guardian Name			Home Phone		
Mobile Phone			Work Phone		
Home Address			Email		
Emergency Contact (other than above)			Home Phone		
Mobile Phone			Work Phone		
Home Address					
Children will only be released to a parent or a person designated by the parent/guardian after verification of ID. I hereby authorize the program to allow my child to leave ONLY with the following persons. Please list name and telephone number.					
Name		Phone		Relationship to Child	
Name		Phone		Relationship to Child	
<input type="checkbox"/> MY CHILD HAS PERMISSION TO BE RELEASED TO THE CARE OF HIS/HER SIBLING(S) UNDER THE AGE OF YEARS.					

SECTION V | AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

I hereby give consent for my child(ren) to be transported and supervised for emergency medical care. In the event I cannot be reached to make arrangements for emergency medical care, I authorize the program to transport my child to:

Physician		Phone	
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Address			
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Emergency Medical Care Facility		Phone	
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Address			
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I GIVE CONSENT FOR THE PROGRAM TO SECURE ANY AND ALL NECESSARY EMERGENCY MEDICAL CARE FOR MY CHILD.

SECTION VI | PARENT/GUARDIAN CONSENT

For each section below, check the box(es) indicating whether or not you give your consent.

TRANSPORTATION:

I hereby give do not give - my consent for my child to be transported/supervised by the operations employees to walk home.

I hereby give do not give - my consent for my child to be transported/supervised by the operations employees to and from home.

I hereby give do not give - my consent for my child to be transported/supervised by the operations employees to and from City Connections project site.

FIELD TRIPS: I hereby give do not give -my consent for my child to participate in field trips.

MEDIA/VIDEO RELEASE: I hereby give do not grant my child permission to be photographed/videoed/and-or interviewed. It is my understanding that this photograph/interview or portions thereof will be used for public view and there will be no financial remuneration for said photograph, video or interview.

SECTION VII | PARENT/GUARDIAN SIGNATURE

A parent/guardian signature indicates that all information on this document represents a complete and accurate statement of the family's circumstances at the time of application.

PARENT/GUARDIAN SIGNATURE		DATE	
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