2018-2019
After School Enrollment Application

Child

First _____ Middle _____ Last_____

Gender: Male _ Female_

School Name _____ Grade _____

Birth date ____/____/_____ Age: ____

Street Address_____

Town/City _____ State _____ Zip code _____

Child's Home Phone _____

Parent/Guardian - Contact Information

Parent/Guardian #1

First_____Last_____Ms. Mrs. Mr. Other

StreetAddress_____

Town/City _____ State ___ Zip Code _____ Home Phone _____

Work Phone _____

Cell phone _____E-mail _____

Occupation_____Employer_____

Parent/Guardian #2

First_____Last_____Ms. Mrs. Mr.

Street Address_____

Town/City _____ State ___ Zip code _____

Home Phone _____ Day time phone _____

Cell phone _____

E-mail _____

Occupation _____ Employer _____
Please list those people including in addition to parents/guardians who are permitted to pick up your child. Please note that these individuals may be subject to identification check.

1:Name_____Phone_____

2:Name_____ Phone_____

3:Name_____Phone_____

Please list any medical problems, including any requiring maintenance medication (i.e. Diabetic, Asthma, Seizures).

Medical Problem	Required treatment	Should paramedic be called?
_____	_____	Yes/No
_____	_____	Yes/No
_____	_____	Yes/No

Is your child presently being treated for an injury or sickness, or taking any form of medication for any reason? Yes__ No__

If yes, explain:_____

Is your child allergic to any type of food or medication?
Yes__ No__ If yes, explain:_____

Does your child require a special diet? Yes__ No__
If yes, explain:

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem, which may interfere with or alter treatment.

In case of medical emergency contact:

	Name	Phone #	Relationship to Child
Contact #1			
Contact #2			
Contact #3			

I understand that I will be notified in the case of a medical emergency involving my child. In the event that I cannot be reached, I authorize the calling of a doctor and the providing of necessary medical services in the event my child is injured or becomes ill.

Parent's/Guardian's Initials _____

I understand that the Extended Arms will not be responsible for the medical expenses incurred, but that such expenses will be my responsibility as parent/guardian.

Parent's/Guardian's Initials _____

Please circle how you heard about the Extended Arms Summer Program.

After School Program Website School Word of Mouth Flyer Other_____

Terms of Agreement

Photo Release

I hereby give permission for my child to be photographed during the **Extended Arms After School Care**. I understand the photos will be used to keep a journal of activities, to share during power point presentations and/or reports to our donors and for promotional purposes including flyers, brochures, newspaper and on the internet. I understand that although my child's photograph may be used for

advertising, his or her identity will not be disclosed, I do not expect compensation and that all photos are the property of Extended Arms,

Parent's/Guardian's Initials _____

Transportation Release

I hereby give permission for the transportation of my child for official activities by **Extended Arms** modes of transportation agreed to by the organizers.

Parent's/Guardian's Initials _____

Extended Arms Randolph Inc, is not responsible for lost or damaged personal property. All scheduled events are subject to change. I understand that no fees will be refunded or transferred unless a child is unable to participate due to an accident or illness per physician orders. Children's' photos and quotes may be used for publicity purposes. In case of an emergency, and if a family physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel (i.e. EMT, First Responder, and/or Physician).

Health/Records Immunization

I hereby confirm that my student is currently enrolled in a school district/facility that requires up-to-date health and immunization records and these forms have been turned into the appropriate record keeper.

Parent's/Guardian's Initials _____

Guardian Signature: _____

Date: _____

Printed Name of Parent/Guardian: _____

FOR OFFICE USE ONLY;

Intake Administrator _____ Voucher or Private_____

Start Date:_____ Initial Payment Received_____

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM

Child's Name: _____ Date of Birth: _____

I authorize staff in the child care program who are trained in the basics of first aid/CPR to give my child first aid/CPR when appropriate.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and/or to _____, and to secure necessary medical treatment for my child.

Child's Physician Name: _____
Address: _____
Phone Number: _____

Child's Allergies: _____
Chronic Health Conditions: _____

Emergency Contacts (*In order to be contacted*)
Name_____
Address_____
Relationship to child_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No_____

Name_____
Address_____
Relationship to child_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No_____

Name_____
Address_____
Relationship to child_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No___

Health Insurance Coverage_____ Policy #_____

Parent/Guardian Name: _____ Phone_____ Cell_____

Parent/Guardian Name: _____ Phone_____ Cell_____

_____ _____
Parent /Guardian Signature Date (valid for one year)