Community Connections Registration Form 2019-2020

Student's Name _____ DOB _____ Sex _____ Grade *(2019-2020)*_____

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School _____ **E-mail Address** _____

(Please provide your e-mail as this is our primary contact method)

Student's Address _____
Street Town State Zip

1. Name of Parent/Guardian_____

Phone (h) _____ Phone (w) _____ Phone (c) _____

Address *(if different from above)* _____

2. Name of Parent/Guardian_____

Phone (h) _____ Phone (w) _____ Phone (c) _____

Address *(if different from above)* _____

With whom do the children live? _____

How will your children get home after Community Connections activities?
Picked up ____ Walk home_____ Other_____

☆ **What information can you share with us to help us best meet your child's needs?** _____

_____

_____

MUST Complete Below Area:

Safety is our top priority; no child will be released from the program without a **parent/guardian signature** or that of one of the 3 individuals listed below *(the names listed must be of someone 16 years or older)*:

Name_____Phone_____Relationship_____

Name_____Phone_____Relationship_____

Name_____Phone_____Relationship_____

►I give permission for the school nurse to share my child's immunization records with CC personnel.
□ **yes** □ **no**

►I understand photographs or videos may be taken for publicity purposes. I give permission for my child's image to be used.
□ **yes** □ **no**

►I understand some of the programs are off school grounds and there are various walking fieldtrips. I give permission for my child to leave school grounds and be transported if necessary. I will receive prior notice of any such off school plans.
□ **yes** □ **no**

►I give permission for surveys to be given to my child and his/her family for purposes of program evaluation.
□ **yes** □ **no**

►I give permission for CC staff to apply sunscreen and bug spray to my child.
□ **yes** *(School Sunscreen may be used)* □ **yes** *(We, the family, will provide a sunscreen)* □ **no**

Return this form to your school's Site Coordinator, scan to: kbolduc@u32.org, or mail to: Community Connections, 1130 Gallison Hill Rd., Montpelier, VT 05602.

Medical Information

Does your child(ren) have any allergies? *(food, drug, insect, etc.)* ___Yes* ___No *If yes, please describe:

Child's name and allergies: _____
Child's name and allergies: _____
Child's name and allergies: _____
Does your child(ren) have: *(Please check **ALL** that apply, give child's name)*

___Contact lenses ___Glasses ___Seizures ___Asthma ___Heart trouble ___Other *(specify)*

How do you control the condition?

_____

☆**Are there any social, emotional, behavioral, or health conditions that we should be aware of?**

_____

_____

Doctor _____ Phone_____

Dentist _____ Phone_____

Date of child's most recent physical or well child exam: _____
Is your child(ren) currently taking any medication? ____Yes ____No
If yes, child's name & description: _____
2nd child's name & description: _____
3rd child's name & description: _____

Does this medication need to be given during program time? ___Yes* ___No

If yes, you must contact the Site Coordinator before your child starts the program.

Release

I hereby give permission for my child(ren) to participate in Community Connections Programs. I assume all risks and hazard incidental to such participation, including transportation to and from activity. I hereby waive, release, absolve, indemnify, and agree to hold harmless Community Connections, Montpelier Public Schools, and Washington Central Supervisory Union, their officers, agents, officials, employees and volunteers, the organizers, sponsors, supervisors and participants for any claim arising out of an injury to my child.

Emergency Contact ***(you MUST list two)***

In the event of an emergency, if I cannot be contacted, I authorize the following persons to act on my behalf:

Emergency Contact #1 _____

Relationship _____ Home # _____ Work #_____

Emergency Contact #2 _____

Relationship _____ Home # _____ Work #_____

Medical Release

In the event that my child(ren) is injured or needs medical help I understand that hospital personnel will attempt to contact me before administering treatment to my child. I authorize Community Connections staff to obtain emergency medical care for my child from a hospital or physician at my expense. I understand I will be notified first if at all possible.

Signature of Parent or Guardian: _____ Date_____