

**Must be completed by a Parent/Guardian**

**QUAD A AFTER-SCHOOL PROGRAM at Dr. Louis A. Cerulli School No. 34**  
**Enrollment Form Academic Year 2017-2018**

**FAMILY INFORMATION:**

Mother/Guardian Name _____	Father/Guardian Name _____
Address _____	Address _____
Home Phone _____	Home Phone _____
Work Phone _____	Work Phone _____
Cell Phone _____	Cell Phone _____

*In case of emergency, which parent/guardian should we contact first?      Mother      Father (Check)*

**Names of Children who attend #34 and want to participate in Quad A's after-school program:**

Please include Siblings only; other Family Members (I.E Cousins) must complete their own Application

**Were your children in Quad A in Previous Years?      Yes      No (Check) If so, What Year? \_\_\_\_\_**

Name _____	D.O.B _____	Age _____	M F (Circle I)
Name _____	D.O.B _____	Age _____	M F (Circle I)
Name _____	D.O.B _____	Age _____	M F (Circle I)
Name _____	D.O.B _____	Age _____	M F (Circle I)

**HEALTH INFORMATION**

*Have any health concerns or information changed within the previous year? (Allergies, Diagnoses, Insurance Information)*  
*If so please indicate below:*

\_\_\_\_\_  
\_\_\_\_\_

**EMERGENCY INFORMATION**

*In case of emergency and the staff are unable to reach the parent/guardian listed above, the following individuals have permission to make decisions regarding the care of my child, including permission to pick up my child from the program.*

Name _____	Name _____
Relationship to child _____	Relationship to child _____
Home phone _____ Work phone _____	Home phone _____ Work phone _____
Home address _____	Home address _____

*If my child requires emergency medical care and I cannot be reached, I give my consent to the School #34/Quad A after-school program to obtain the necessary medical care for my child. I agree to pay all of the costs associated with the emergency medical care that my child receives. \_\_\_\_\_*

**Parent Signature**

**CHILD PICK-UP AUTHORIZATION**

*I give permission for my child to be released from the School #34/Quad A after-school program to the people listed below at any time. I understand the staff requires these people to furnish photo identification before releasing the child.*

Name _____	Name _____
Relationship to child _____	Relationship to child _____
Home/Cell Phone _____	Home/Cell Phone _____
Name _____	Name _____
Relationship to child _____	Relationship to child _____
Home/Cell Phone _____	Home/Cell Phone _____

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**HEALTH INFORMATION:** Please check each of the following health challenges or allergies that each of your children has.

**CHILD NAME:** \_\_\_\_\_

Name

**Health**

- |  |                                      |  |
|--|--------------------------------------|--|
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Emotional/<br>Psychological |
| <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Hearing     | <input type="checkbox"/> Learning                    |
| <input type="checkbox"/> Special diet          | <input type="checkbox"/> Vision      | <input type="checkbox"/> Disabilities                |
| <input type="checkbox"/> Physical restrictions | <input type="checkbox"/> Injury      | <input type="checkbox"/> ADD/ADHD                    |
| <input type="checkbox"/> Other                 | <input type="checkbox"/> Operations  |  |

**Allergies**

- |                                       |
|---------------------------------------|
| <input type="checkbox"/> Hay fever    |
| <input type="checkbox"/> Poison ivy   |
| <input type="checkbox"/> Insect bites |
| <input type="checkbox"/> Medication   |
| <input type="checkbox"/> Food         |
| <input type="checkbox"/> Other        |

Please explain the details of the items you checked above. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is your child currently taking prescribed or over-the-counter medication? If so, what? \_\_\_\_\_

Is your child covered by any hospitalization/medical care policy?  Yes  No

Insurance Company \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_

Policy Holder's Date of Birth \_\_\_\_\_ Policy #(include all letters and numbers) \_\_\_\_\_

Does your child have a doctor?  Yes  No

Name of doctor \_\_\_\_\_ Phone \_\_\_\_\_

Does your child have a dentist?  Yes  No

Name of dentist \_\_\_\_\_ Phone \_\_\_\_\_

Is there any other health/medical information we should know? \_\_\_\_\_

**Child Profile**

The following information will help us to better understand your child and his/her needs.

1. Why do you want your child in this program?  
\_\_\_\_\_
2. Does your child display any emotional fears, behavior problems, or difficulties in dealing with others?  
\_\_\_\_\_
3. What techniques of discipline do you find most effective?  
\_\_\_\_\_
4. Who does your child live with and what is his/her relationship to him/her?  
\_\_\_\_\_
5. If you could describe your child in one phrase, what would it be?  
\_\_\_\_\_
6. What activities should your child be encouraged to do?  
\_\_\_\_\_
7. Are there any activities that your child cannot participate in?  
\_\_\_\_\_
8. Is there anything else we should know about your child?  
\_\_\_\_\_

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**Parent/Guardian Agreement**

**CHILD (REN) NAME:** \_\_\_\_\_

- I, the undersigned, hereby enroll my child (ren), in the Quad A/School #34 after-school program. I understand that the program assumes responsibility for my child (ren)'s well-being during the hours of the program and will make every effort to immediately contact me should any type of emergency arise.
- I have provided the staff with pertinent, complete, and correct information that will assist them in caring for my child (ren) and will update that information when necessary.
- The program's responsibility for my child (ren) begins when they reach the program and check in with a staff member. My child (ren) is responsible for walking from the classroom to the program.
- I give my consent for my child (ren) to take part in field trips away from the facility under proper supervision and to be transported by bus when necessary, including for swimming.
- I give my consent that any photographs/videos of my child (ren) may be used in promotional material such as brochures, web sites, or newspaper releases. I understand that I will not be informed or reimbursed for such photographs/videos.
- I give my consent for the after-school program to use school records and discussions with school staff to help understand my child and in the evaluation of the program.
- **I understand that it is my responsibility to arrange for my child (ren) to be picked up from the program at Dismissal Time. If my child (ren) are not picked up on time, I understand that I will be charged \$1 for every minute that I am late and that my child (ren) will not be allowed back in the program until I pay the amount owed. (Should bus transportation be provided, this clause will not apply.)**
- Should a person arrive to pick up my child (ren) who appears to be under the influence of drugs or alcohol, for my child (ren)'s safety, staff may need to contact the police.
- I understand that the after-school program staff is mandated, by state law, to report any suspected cases of child abuse or neglect to the appropriate authorities.
- I understand that daily attendance at the program is important for the development of my child. Therefore, I understand that Quad A will replace my child with a child who is on the waiting list if my child is excessively absent from school and/or the after-school program.

My signature acknowledges my understanding of and agreement to the above and that all the information I provided is accurate and complete.

\_\_\_\_\_  
Parent/Guardian Name (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

**Communication Methods (Please Complete):**

**Mother's/Guardian Cell:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Father's/Guardian Cell:** \_\_\_\_\_ **Email:** \_\_\_\_\_