



Sara Holbrook Community Center
February Vacation Camp (Feb. 28- March 1)
Registration Form 2019

One form per child must be filled out by a parent or guardian

CHILD'S INFORMATION:

Child's Name: Nickname:

Gender: Male Female Transgender Gender Unspecified Date of Birth: Age:

School Name: Grade:

During the school year, does your child have any of the following: Individual Aide (IA)? Yes No

Individual Education Plan (IEP)? Yes No

Behavior Management Plan? Yes No

FAMILY INFORMATION:

Race/Ethnicity Language(s):

Parent(s)/Legal Guardian(s):

Name(s): Email Address

Address:

Street Address City State Zip

Primary Phone #: Secondary Phone #:

Place of Work: Work Phone #:

Other Parent(s)/Guardian(s): (only complete if there is a shared custody agreement)

Name(s):

Address:

Street Address City State Zip

Primary Phone #: Secondary Phone #:

Place of Work: Work Phone #:

EMERGENCY CONTACT #1:

(This must be someone other than the parent/guardian, and will be used if the parent/guardian cannot be reached)

Contact Name: Relationship:

Primary Phone #: Secondary Phone #:

EMERGENCY CONTACT #2:

(This must be someone other than the parent/guardian, and will be used if the parent/guardian cannot be reached)

Contact Name: Relationship:

Primary Phone #: Secondary Phone #:

OTHERS AUTHORIZED TO PICK-UP: (SHCC reserves the right to ask authorized person for identification)

1. NAME RELATIONSHIP PHONE #

2. NAME RELATIONSHIP PHONE #

Transportation: (Please put a check mark on the lines next to your child's method of transportation.)

My child will be:

Walking to the Center without adult supervision Walking home from the Center without adult supervision

Dropped off at the Center by an authorized adult Picked up at the Center by an authorized adult

Child's Name: _____ Gender: M F DOB: ____/____/____

MEDICAL INFORMATION:

Insurance Information:

Is your child covered by family medical/hospital insurance? Yes No
If yes, indicate carrier or plan name: _____ Group ID # _____
Child's Physician: _____ Phone #: _____
Child's Dentist/Orthodontist: _____ Phone #: _____

HEALTH HISTORY:

Medication:

Does your child take medication that needs to be administered during camp hours?
 Yes No
Is your child required to carry an epinephrine pen with him/her at all times? Yes No

Allergies:

Does your child have any allergies to food, medication or the environment? Yes No
If yes, please describe in detail the source of the allergy, reaction and the management or care needed.

Medical Conditions:

Does your child have any Medical Conditions that we need to be aware of? Yes No
If yes, please describe in detail the condition and the management or care needed.

Additional Information: Please provide any additional information about your child's behavior, and/or physical, emotional, food, or mental health concerns that the staff should be aware of:

Your Child's School

Address of School

Telephone Number of School

CONSENT FORM FOR THE RELEASE OF A STUDENT'S EDUCATION RECORDS

This Consent Form **must be filled out and submitted** to the District before the District can comply with the parent or eligible student's request to release information, other than Directory Information, regarding a student, to The Sara Holbrook Community Center, the "After School Program."
(Name of Afterschool Program)

Name of Student: _____, the "Student"

I. Specifications of the education records to be disclosed: Any and all education records of the Student maintained by the District that the After School Program believes will assist it in meeting the educational needs of the Student and improving the Student's educational achievement. Such records may include or be relevant to, but are not limited to:

- First and last name
- Date of birth
- Student ID number
- Race/ethnicity
- Gender
- IEP
- Bilingual/Limited English Proficiency
- Free/reduced lunch
- Parent/guardian name
- Email address(es)
- School attending
- Phone numbers
- Grade Level
- Special education
- Scores on standardized tests
- Progress Monitoring Assessment Data
- Student behavior data
- Student Attendance
- Medical Records (including immunizations)
- Address
- Grades

II. The purpose(s) of disclosure is/are: To improve instruction and other out-of-school time services that promote the Student's success in school, to meet the needs of the Student more effectively, to equitably support students from all demographic segments of the population, to identify gaps in service, and determine whether these programs are supporting student achievement in alignment with educational needs as well as creating a culture of positive behavior and strong youth engagement.

III. Describe the party or class of parties to whom the disclosure may be made: The After School Program's staff who work with the student and or staff who record data relating to the student's participation and progress in the After School Program.

My signature below demonstrates my consent to the release of the above named Student's education records to the After School Program, all as more fully described above. This Consent is valid from September 1 through August 31 of the current school year.

Parent or Guardian of Eligible Student

Date

Copies of the Disclosed Education Record(s) are available upon request to parent(s) or eligible student(s). If you have any questions regarding this request, please call your child's school.



101050-11 Consent for Afterschool

AUTHORIZATION

Consent & Medical Authorization: I attest that the information above is true and correct to the best of my knowledge, and I am fully aware of the risk inherent. I hereby give my consent for my child, listed above, to participate in the SHCC program indicated. The person herein described has permission to engage in all activities, except as noted. I agree to hold harmless the Sara Holbrook Community Center, its employees, or volunteers from any and all liability from any injury, claims, costs, or loss of service which might be incurred by participation in said programs, related activities or events. I understand that medical insurance coverage is not provided. I hereby give permission to the staff to provide routine health care (including the application of non-prescription medications and products, ointments, creams, tick and insect repellents, sunscreen, and other topically applied ointments and lotions as deemed necessary). I agree to the release of any of the above-described information for the necessary treatment, referral, billing, or insurance purposes. In the event of an emergency and I cannot be reached, I hereby give permission to the program to arrange necessary related transportation for my child and give permission to the attending physician to secure and administer treatment, including hospitalization. _____ Initials

Waiver: In consideration of your accepting my child's entry, I hereby, for myself, my child, my heirs, executors and administrators, waiver and release any and all rights and claims for damages I or my child may have against the Burlington Parks District, the Burlington School District, or the Sara Holbrook Community Center and its representatives, successors, and assigns for any and all injuries suffered by myself or my child at any activity sponsored by these groups. _____ Initials

Permission to Access Immunization Records: (It is a licensing requirement that the Sara Holbrook Community Center have a copy of your child's immunization records on file.) I give permission for the Sara Holbrook Center to access my child's immunization records through the Vermont Immunization Registry. _____ Initials

Photo Consent: Registration for the Afterschool Program grants permission to Sara Holbrook Community Center to photograph or videotape your child for possible use in publications, promotional materials, social media sites, or grant reports. _____ Initials

PG Movies: I grant my child permission to view PG-rated movies. _____ Initials

Transportation: I grant my child permission to be transported by Sara Holbrook approved Staff or contracted bus service while attending and participating in Sara Holbrook related activities. _____ Initials

Field Trips: I grant my child general permission for walking field trips. Parents will be notified and location and estimated time of return will be posted on Sara Holbrook's door. _____ Initials

I have read the above waiver carefully and sign it voluntarily with full knowledge of its significance

Name of Child: _____ Child's Date of Birth: _____

Parent/Guardian's Name Printed: _____

Parent/Guardian's Signature: _____ Today's Date: _____