# AFTER SCHOOL PROGRAM REGISTRATION FORM 2016/2017

## PARTICIPANT INFORMATION

Name: _____ Birth Date: _____ Age: ___ Gender: ___

Address: _____ Phone: _____

School: _____ Grade: _____

## PARENT/GUARDIAN INFORMATION

Parent/Guardian 1: _____

Home Phone: _____ Cell: _____ Work: _____

Email Address: _____

Parent/Guardian 2: _____

Home Phone: _____ Cell: _____ Work: _____

Email Address: _____

## EMERGENCY CONTACTS

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

## MEDICAL INFORMATION

Family Doctor: _____ Phone: _____

Health Card Number: _____

Allergies: _____

Medications Taken: _____

Health Conditions: _____

Other Notes: _____

## PROGRAM INFORMATION

Please indicate the days that you would like your child to attend the After School Program:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

## PARTICIPATION PERMISSION

I give permission for my son/daughter/ward, to participate in ACCESS' After School Program offered at Queen of Peace. I relieve ACCESS, its directors, staff, and volunteers from all responsibility in case of personal injury and/or property damage resulting from behaviour of my child which is contrary to established rules and/or procedures of Access County Community Support Services. I will also be responsible for any personal injury and/or property damage caused by the misconduct or negligence of my child.

_____ _____

Parent/Guardian Signature Date

## CONFIDENTIALITY

All information pertaining to the child and the child's situation is to be kept confidential. A parent or guardian signed "Release of Information" form is needed in order to allow the exchange of information with any other outside agency (ie schools, other service agencies). The only exception of document or information access without parental permission would be access by the courts, in response to a court order or warrant.

_____ _____

Parent/Guardian Signature Date

## MEDIA RELEASE

Please check and sign the appropriate statement.

☐ I hereby give permission for my son/daughter/ward _____to be photographed/video taped during the Access County Community Support Services activities for the purpose of promotion and/or for Access County Community Support Services' own photo collection which may be used to promote the organization at a future time. I understand that these photographs/videos will be the property of Access County Community Support Services and may be used in flyers, brochures, posters, newspapers, video, social media (ie., Facebook, Twitter, Agency Website), and other promotional items that Access County Community Support Services deems appropriate.

☐ I do not grant permission for my son/daughter/ward to be photographed or video taped by Access County Community Support Services for the purpose of promotion of ACCESS programs.

_____ _____

Parent/Guardian Signature Date

# METHODS OF OPERATION

1. Hours of Operation
   Monday to Friday – After School until 6 p.m.

2. Ages for Program
   Children & Youth – Grades 1-8

3. Discharge Policy
   Parents are free to withdraw their children from the program at any time. Parents must notify staff of this change.

4. Late Pick-Up
   There will be a fee charged for any pick-ups that occur after 6 p.m. A fee of $5.00 will be applied in 15 minute increments.
   Examples: A fee of $5.00 for any pick-up that occurs between 6:00 and 6:15. $10.00 for any pick-up that occurs from 6:15-6:30, etc.

5. Absenteeism
   If your child will not be attending on their scheduled day, the Youth Centre needs to be informed by 1:30 pm. Failure to report your child's absence from the program three times will result in termination from the After School Program.

6. Program Cancellations
   a. If school buses are not running for any reason, there will be NO After School Program. If the buses are only cancelled for the morning due to fog, the After School Program will still be cancelled. If you choose to bring your child(ren) to school on these days, you are responsible for arranging pick-up and child care for your children after school. The After School Program Staff are NOT responsible for picking up your child on these days. The After School Program will also NOT be running on Holidays or P.A. Days.

Please sign to indicate that you have read and understand the following After School Program Methods of Operation.

_____ _____

Parent/Guardian Signature Date

Access County Community Support Services

# Transportation Authorization

I give permission for my son/daughter/ward _____ to walk with or be transported (motor vehicle) by a staff or volunteer driver:

From _____ School to Access County Community Support Services

From Access County Community Support Services to community projects in Kingsville/Leamington (Seniors residence, park, town clean up, etc.)

From Access County Community Support Services  Program Events (library trip, movie trip, field trips).

I agree to indemnify and save harmless Access County Community Support Services, its directors, staff, and volunteers from all claims for injuries or losses of any kind whatsoever that may arise as a result of the transportation being provided by Access County Community Support Services, or as a result of the behaviour/negligence of my child whatsoever and that is contrary to established rules and/or procedures of Access County Community Support Services and that may arise directly or indirectly from their conduct.  I will also be responsible for any claims for injury and/or property damaged caused by the misconduct or negligence of my child/ward.

_____ _____

Parent/Guardian Signature Date

Access County Community Support Services

# Authorization for Participant Pick-Up

I _____ give authorization for the following people in addition to the Parents/Guardians listed on the registration form, to pick up my child _____ from the After School Program held at Access County Community Support Services Leamington Site:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

_____ _____

Parent/Guardian Signature Date

Access County Community Support Services

## Authorization to Walk Home

I _____give my child_____ permission to be released to walk home at (time) _____, the end of the After School Program. (permission accepted for those 10 years and older, and granted to those under 10 years if they are accompanied by a youth age 12 years or older)

I agree to indemnify and save harmless Access County Community Support Services, its directors, staff and volunteers from all claims for injuries or losses of any kind whatsoever that may arise as a result of the behaviour/negligence of my child whatsoever while walking home after the program and that is contrary to established rules and/or procedures of Access County Community Support Services and that may arise directly or indirectly from their conduct. I will also be responsible for any claims for injury and/or property damage caused by the misconduct of my child/ward.

For my child (under 10), I give permission for them to walk home with the following:
***(must be accompanied by someone 12 years or older)***

Name _____ Age _____ Phone_____

Name _____ Age _____ Phone_____

Name _____ Age _____ Phone_____

Name _____ Age _____ Phone_____

_____ _____

Signature of Parent/Guardian Date

## Access County Community Support Services
## Physician Certification of Existing Medical Condition

Name of Child:_____ Date of Birth:_____

I, _____, attending physician of the above-named child, do hereby
(Name of Physician – please print)
state that this child has the following medical condition(s).

| Category | Specific Condition | Treatment/Medication/Action to be Taken |
|---|---|---|
| Broken Bone(s) * | | |
| Respiratory (eg., Asthma) Cardiac Disorder | | |
| Blood/Endocrine/Immune (eg. Anemia, Hemophilia, Diabetes, HIV) | | |
| Neurological/Muscular Disorder (eg. Epilepsy, MD, MS) | | |
| Development Delays (Physical or Mental) | | |
| Other (please specify) | | |

I have reviewed Access County Community Support Services Program Activities outline and recommend that the above-named child be restricted from the following activities:

1._____
2._____
3._____

Please note: Access County Community Support Services After School Program is unable to accommodate children who are restricted from outdoor play.

_____ _____
Physician Signature Date

_____ _____
Parent/Guardian Signature Date

## Access County Community Support Services
## Consent for Drug Administration

**Name of Child:** _____

**Address:** _____

**Name of Drug:** _____

**Prescription No:** _____

**(*One drug per form. Please inform classroom teacher daily that your child has medicine.)**

**Start Date:** _____

**End Date:** _____

**Time Schedule:** _____

**Dosage:** _____

**Adverse Effects:** _____

**<u>Attention Parents</u>: Medication must be in its original container and clearly marked with your <u>child's name</u>. Doctor's/Nurse Practitioner's note required for non-prescription drugs. Please check to be sure you are taking your own child's medication home from the Centre.**

_____ _____

**Signature of Parent/Guardian** **Date**

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****FOR CENTRE USE ONLY****

### Medication Record

| Date | Drug | Prescription No. | Dose | Time | Child/Comments | Signature | Verified Ownership & Returned by: |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

_____ _____

**Signature of Supervisor/Designate** **Date**

_____

**Date Medication Ceased**

**Epi-Pen Emergency Treatment Plan**

**Child's Name:**_____ **Group:**_____

**Allergic to:**_____ **Staff:**_____

**Epi-pen must be administered immediately upon contact with the allergen. A serious reaction could occur within a very few minutes and <u>death may result.</u>**

**<u>PROCEDURES:</u>** **Retrieve Epi-Pen from storage area and bring to the victim.**

| **<u>PERSON 1</u>** | **<u>PERSON 2</u>** |
|---|---|
| 1. Obtain Epi-Pen from _____ Envelope must be marked clearly with child's name and picture.<br>2. Remove Epi-Pen from plastic container.<br>3. Remove grey cap.<br>4. Place black-tipped end of Epi-Pen against outer thigh and press firmly for 10 seconds.<br>5. Inject. Instructions.<br>6. Place child on side in case of vomiting.<br>7. Return Epi-Pen to container and give to ambulance personnel.<br>8. Accompany Child to the hospital.<br><br>NOTE 1: If child has more than one Epi-Pen prescribed, follow physician's instructions.<br><br>NOTE 2: Proceed with #8 in any event, even if an incident occurs during periods of reduced staff. | 1. Call ambulance (dial 911). Give 911 operator the address and telephone number of the site.<br>2. Call Parents:<br>Home:_____<br>Mother's Work:_____<br>Father's Work:_____<br>3. Note and record here:<br>Time of Incident_____<br>Time of administration_____<br>Circumstances (where) (what was eaten)<br>_____<br>4. Obtain the child's health record. Note below location of child's file.<br>_____<br>5. Give child's health record and this form to the staff member accompanying the child in the ambulance. |

**Epi-Pen with a completed treatment plan form must accompany the child on all outings along with a trained person.**

**Possible signs and symptoms of Anaphylactic Shock:**

1. **Possibility of face swelling.**
2. **Feeling on constriction of the throat and chest with difficulty breathing.**
3. **Extreme weakness.**
4. **Pale, cold and clammy skin.**
5. **Rapid thready pulse.**
6. **Fall in blood pressure.**
7. **Cyanosis (turning blue), coma, abdominal cramps, vomiting and diarrhea may also occur.**

**<u>EPI-PEN SHOULD BE WITHIN EASY ACCESS AT ALL TIMES.</u>**