

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 the After School Program offered at the Access County Community Support Services Harrow Site. 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/Harrow (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 Harrow 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

Release of Information

(This form is used to provide the schools with a weekly list of who is attending the After School Program)

Name of Client (Participant's Name) _____

I, _____ (Parent or Guardian of the above named individual)
hereby

(Print Full Name)

authorize Access County Community Support Services staff to release and request information regarding the above, between the Access County Community Support Services and the following individual/agency:

Name: _____

(Print Full Name of School)

Address: _____

(Address, City, Province, Postal Code)

I also consent to and authorize Access County Community Support Services staff to use information from my child's file for case management purposes with the understanding that no identifying information will be used. I acknowledge and understand that Access County Community Support Services serves my child's needs, consequently, it will be necessary for information to be shared among staff members. I consent to this information sharing.

This consent expires _____ (one year)

This form has been read over and explained to me and I understand the meaning of this document.

Consent Signature

Date

Witness Signature

Date

Witness (Print Full Name)

**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: _____

Attention Parents: Medication must be in its original container and clearly marked with your child's name. 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

****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 death may result.

PROCEDURES: Retrieve Epi-Pen from storage area and bring to the victim.

<u>PERSON 1</u>	<u>PERSON 2</u>
<ol style="list-style-type: none">1. Obtain Epi-Pen from _____ Envelope must be marked clearly with child's name and picture.2. Remove the EpiPen® Auto-Injector from the carrier tube and follow these 2 simple steps:3. Hold firmly with orange tip pointing downward. Remove blue safety cap by pulling straight up. Do not bend or twist.4. Swing and push orange tip firmly into mid-outer thigh until you hear a "click." Hold on thigh for several seconds. <p>There is built-in needle protection - when EpiPen® is removed, the orange needle cover automatically extends to cover the injection needle, ensuring the needle is never exposed. After using EpiPen®, you must seek immediate medical attention or go to the emergency room. For the next 48 hours, you must stay close to a healthcare facility or be able to call 911.</p> <ol style="list-style-type: none">5. Accompany Child to the hospital. <p>NOTE 1: If child has more than one Epi-Pen prescribed, follow physician's instructions.</p> <p>NOTE 2: Proceed with #5 in any event, even if an incident occurs during periods of reduced staff.</p>	<ol style="list-style-type: none">1. Call ambulance (dial 911). Give 911 operators the address and telephone number of the site.2. Call Parents: Home: _____ Mother's Work: _____ Father's Work: _____3. Note and record here: Time of Incident _____ Time of administration _____ Circumstances (where) (what was eaten) _____ _____4. Obtain the child's health record. Note below location of child's file. _____ _____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.

EPI-PEN SHOULD BE WITHIN EASY ACCESS AT ALL TIMES.