FOUNDATIONS
AFTERSCHOOL PROGRAMS

Registration Checklist

(Completed by Foundations staff)

☐ School Year 2017-18

Child's Name: _____ Enrollment Date_____
Start Date_____

Identification #:_____

(Check if completed and signed)

☐ Registration fee (amount _____), paid _____yes _____no
☐ Student Registration Form
☐ Agreement
☐ Child Health Assessment Date _____
☐ Student Records Release Form
☐ Civil Rights Compliance
☐ Field Trip Permission Form
☐ Photo/Media Release
☐ Emergency Medical Care and First Aid Authorization Form
☐ Emergency Contact/Parental Consent Form
☐ Daily Dismissal Schedule

Fifth month review of information:

_____
Parent's Signature

_____
Staff Signature

FOUNDATIONS, INC.

Date:	**REGISTRATION** **- please print -**	Site: Christopher Columbus Charter School

STUDENT INFORMATION: School, if different from program site _____

Name: _____Gender: M F (Circle One)

School I.D. #:_____

Date of Birth: _____/_____/_____ Program/Grade:_____ Starting Date:_____/_____/_____
Month Day Year

Parent/Guardian of Record (Name): _____

Street: _____ Apt. #: _____

City: _____ State: _____ Zip:_____

Phone contact: (HOME) _____(WORK) _____ _____(CELL) _____

Racial/Ethnic Group: (Circle One) ⟶ Black Hispanic Indian or Alaskan Pacific Islander White

☐ √ if registration fee is paid

☐ √ if AM only

☐ √ if PM only

☐ √ AM & PM

☐ √ ____sibling(s)

AGREEMENT

55 PA CODE CHAPTERS 3270.123 &.181(C); 3280.123 & .181(c); 3290.123 &.181(c)

NAME OF CHILD		
FEE AMOUNT $	PER-DAY-WEEK	DAY PAYMENT TO BE MADE
Services to be provided as part of the day care fee (examples; transportation, care, meals, etc.)		
CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
LATE FEE **$ 1.00**	**PER MINUTE**	
Extra services to be provided at an additional fee if applicable		

I, the parent/guardian;

☐ received complete written program information at the time of enrollment (§ 3207.121, 3280.121, 3290.121)

☐ agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minimum. (§ 3270.124, 3280.124, 3290.124)

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SIGNATURE-OPERATOR DATE

SIGNATURE-PARENT OR GUARDIAN DATE

DATE OF CHILD'S ADMISION
DATE OF WITHDRAWAL

PERIODIC REVIEW	
SIGNATURE-PARENT OR GUARDIAN	DATE

CHILD HEALTH ASSESSMENT

Parents & Child Care Providers fill-in this part.

CHILD'S NAME: (LAST)	(FIRST)
DATE OF BIRTH:	HOME PHONE:
CHILD CARE FACILITY NAME:	
FACILITY PHONE:	COUNTY:

PARENT/GUARDIAN:
ADDRESS:
WORK PHONE:

PA child care providers must document that enrolled children have received age appropriate health services and immunizations that meet the current schedule of the American Academy of Pediatrics 141 Northwest Point Blvd., Elk Grove Village, IL 60007. The schedule is available at < www.aap.org > or Faxback 847/758-0391 (document #9535 and #9807). Print copies provided by DPW have the schedule on the back of the form.

Health history and medical information pertinent to routine child care and emergencies (describe, if any):

❒ **NONE**

Allergies to food or medicine (describe, if any):

❒ **NONE**

Date of most recent well-child exam:

_____

Do not omit any information. This form may be updated by health professional. (Initial and date new data.) Child care facility needs 2 copies.

LENGTH/HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	BLOOD PRESSURE
_____IN/CM %ILE _____	_____LB/KG %ILE _____	_____ IN/CM %ILE _____	(BEGINNING AT AGE 3) _____ / _____

PHYSICAL EXAMINATION	☑ =NORMAL	IF ABNORMAL - COMMENTS
HEAD/EARS/EYES/NOSE/THROAT		
TEETH		
CARDIORESPIRATORY		
ABDOMEN/GI		
GENITALIA/BREASTS		
EXTREMITIES/JOINTS/BACK/CHEST		
SKIN/LYMPH NODES		
NEUROLOGIC & DEVELOPMENTAL		

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
DTaP/DTP/Td						
POLIO						
HIB						
HEP B						
MMR						
VARICELLA						
MENINGOCOCCAL						
PNEUMOCOCCAL						
INFLUENZA						
HEP A						
ROTAVIRUS						
OTHER						

SCREENING TESTS	DATE TEST DONE	NOTE HERE IF RESULTS ARE PENDING OR ABNORMAL
LEAD		
ANEMIA (HGB/HCT)		
URINALYSIS (UA) at age 5)		
HEARING (subjective until age 4)		
VISION (subjective until age 3)		
PROFESSIONAL DENTAL EXAM		

HEALTH PROBLEMS OR SPECIAL NEEDS, RECOMMENDED TREATMENT/MEDICATIONS/SPECIAL CARE (ATTACH ADDITIONAL SHEETS IF NECESSARY)

❒ **NONE**

NEXT APPOINTMENT - MONTH/YEAR:

MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN OR CRNP:	
ADDRESS:			
	PHONE:	LICENSE NUMBER:	DATE FORM SIGNED:

Parents may write immunization dates, health professionals should verify and complete all data.

STUDENT RECORD RELEASE FORM

Child's Name_____ Date of Birth_____

Program Site_____

Parent/Guardian Name_____

Address_____ Phone Number_____

I authorize _____
Program Site and Lead Teacher

Check One:
_____ to release the information specified below to:
_____ to obtain the information specified below from:

Name, Title, Organization_____

Address_____

Purpose of request: _____

With this permission I also release Foundations, Inc. and its employees from any and all liability and all claims pertaining to the disclosure of this information.

School records may be examined by parent/guardian or student (age 18 or older). A copy of this consent form will be provided upon request. Information to be released:

___ Test results and other non-directory educational information
___ Health record
___ Staff observations
___ Child study/special education Records
___ Social work reports
___ Psychiatric reports
___ Medical records
___ Psychological reports
___ Other (specify) _____
_____

I understand this authorization takes effect the day I sign it. It expires no more than one year from the date of my signature. I also understand that I may revoke this authorization at any time by sending a written request to the Lead Teacher. I may refuse to sign this authorization and it will not affect my child's ability to participate in the afterschool program. I understand that I am entitled to a copy of this authorization. I understand that the laws that protect the information disclosed may allow or require re-disclosure of the information, but only as permitted by law.

_____ _____
Signature of Parent/Guardian Date

FOUNDATIONS, Inc.

Serving children, families and communities

Civil Rights Compliance

Parent/Guardian Awareness

In accordance with applicable Federal and State civil rights laws and regulatory requirements, you and your children, as a client of this facility, have the right:

- To be provided services at this facility and to be referred for services at other facilities without regard to your race, color, religious creed, ancestry, national origin, age, sex, or physical disabilities.

- To file a complaint of discrimination if you feel you have been discriminated against on the basis of your race, color, religious creed, ancestry, national origin, age, sex, or physical disabilities. Complaints of discrimination may be filed with any of the following:

FOUNDATIONS
701 East Gate Drive, Suite 300
Mt. Laurel, NJ 08054

Region III, P.O. Box 13716
Philadelphia, PA 19101
(within 180 days of incident(s)

Department of Public Welfare
Civil Rights Compliance Unit
502 – State Office Building
1400 Spring Garden Street
Philadelphia, PA 19130
(within 90 days of incident(s)

Pennsylvania Human Relations Commission
711 State Office Building
1400 Spring Garden Street
Philadelphia, PA 19130
(within 180 days of incident(s)

Office for Civil Rights
U.S. Department of Health and Human Services

Federal Office of Civil Rights
U.S. Department of Education
Washington, DC 20202

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FOUNDATIONS Representative Date Parent/Guardian Date

Parent/guardian note: Your signature confirms that you received a Family Handbook that contains all of the Civil Rights Compliance information listed above.

FIELD TRIP PERMISSION FORM

Throughout the school year, field trips will be planned as part of the afterschool program. These field trips are designed to supplement the Center for Afterschool Education at Foundations' program curriculum. Trips may include walking to nearby parks, stores, etc. while at other times students may be bussed to a particular location. You will be notified in advance of any field trips and be provided with specific information regarding them. If for any reason you do not want your child to participate in a field trip, you must notify the Lead Teacher in writing prior to the trip. If your child is excused from the field trip, you will be responsible for your child on that day.

Reasonable precautions will be exercised to assure the safety and welfare of your child. However, we shall not be responsible, neither financially nor in any other respect, should an accident occur.

Please sign this form authorizing your child's participation in field trips for the coming school year.

I hereby give permission for my child to participate in afterschool sponsored field trips.

_____
Parent/Guardian (Please Print)

_____ _____
Signature of Parent/Guardian Date

I also grant permission for my child to receive emergency medical treatment while on a field trip and/or to be hospitalized if necessary. It is understood that every attempt will be made to contact me or the person listed below before taking this action.

Home phone_____

Business phone_____

If I cannot be reached, call _____ _____
Emergency Contact Person Phone Number

_____ _____
Medical Insurance Provider Policy Number

_____ _____
Confirmation Phone Number Name of Insured/Subscriber

_____ _____
Signature of Parent/Guardian Date

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CENTER FOR Afterschool EDUCATION

PHOTO/MEDIA RELEASE

Throughout the year, students are photographed and videotaped at afterschool events and activities. Such photographs, videos, or other illustrating material may be used in newsletters or publications produced by Foundations' afterschool programs, in slide presentations an/or videos about the afterschool program, or in other similar forms of communication.

This form allows you as a parent/guardian to choose whether your child may be in a video, photograph, or other illustration used by Foundations' afterschool programs or the news media.

Please check one:

_____ I hereby consent and authorize Foundations, Inc., its employees, officers, agents, and production company, to receive, reproduce, market, and use any and all photographs/videos produced of my child, and any reproduction(s) thereof, in perpetuity, in any/all media. I further understand that any reproduction(s) will be distributed as widely as possible and that portions may be used for advertising/promotional purposes.

I understand that Foundations, Inc. holds sole ownership interests to the original photographs/videos and/or any/all reproduction(s). I relinquish and assign any rights to the original photographs/videos and/or any/all reproduction(s) and relinquish and assign any rights to compensation for the use of the original photographs/videos and/or any/all reproduction(s).

_____ I do not consent for my child to be included in any pictures. I understand that he/she will be included in all program activities but will not be included in any group or class photographs/videos with others in his/her class or activity.

_____ _____

Signature of Parent/Guardian Date

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Center for Afterschool Education

EMERGENCY MEDICAL CARE AND FIRST AID AUTHORIZATION

Child's Name_____ Birthdate_____

I hereby give permission that my child, _____ be given emergency treatment to include first aid and CPR by qualified afterschool staff. I further authorize and consent to medical, surgical, and hospital care, treatment, and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health and I cannot be contacted. I waive my right to informed consent to such treatment. I also give my permission to inform said physician of my child's medical history and/or to release my child's medical records.

Permission is also granted for my child to be transported by ambulance or car to an emergency center for treatment.

Please list any medications your child is currently taking: _____
_____

Please list all your child's allergies: _____
_____

Signature of Parent/Guardian_____ Date_____

Address: _____ _____
_____ Home Phone
_____ _____
Work Phone

Name of Insurance Company_____ Policy Number_____

Confirmation Phone Number_____ Name of Subscriber_____

Family Physician_____ Phone Number_____

Local Emergency Contact Names Other Than Parent/Guardian. (In order to be contacted.)

Name:	Relationship:	Home Phone:
Address:		Work Phone:
Name:	Relationship	Home Phone:
Address:		Work Phone:

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Center for Afterschool Education

701 East Gate Drive, Suite 300 ● Mt. Laurel, NJ 08054
Tel: 856-533-1600 ● 888-977-5437 ● Fax: 856-533-1601
www.foundationsinc.org

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Subject: Daily Dismissal Schedule

Dear CCCS Afterschool Parent/Guardian,

Foundations staff and the Christopher Columbus administration are always looking for ways to build the quality of our afterschool program. We all recognize how important uninterrupted learning time is to every child's development; therefore, the program dismissal schedule for the 2017-18 year will provide all children with uninterrupted time for homework assistance and enrichment activities. W**e will dismiss students on 1/4hour intervals only, starting at 4:30pm , 4:45pm, 5:00pm, 5:15pm, 5:30pm, 5:45pm and 6:00pm** .

We care very much about the students at CCCS and considered their best interests in this schedule. We ask that you partner with us in this endeavor by planning your daily pick-up time according to the dismissal schedule. Please inform anyone who is listed on the emergency contact list to adhere to the policy.

Please sign the bottom of this form and return to a Foundations afterschool staff member when completing your registration materials. You will also receive a copy for your records. Thank you in advance for your support and cooperation.

Sincerely,

Ronda Silbermann

Ronda Silbermann, Manager, Afterschool and Extended Learning Programs
Rosemary Dougherty, CEO/Principal, Christopher Columbus Charter School

I have received and read the Foundations afterschool program at Christopher Columbus Charter School dismissal procedure and agree to follow the guidelines as written. I will instruct anyone responsible for signing my child out of the afterschool program to do the same.

Student's Name:_____
(please print)

Parent's/Guardian's Name: _____
(please print)

_____ _____
(signature) (date)