2023-24 After School Program Registration

Green Bay Area Public School District

21st Century Community Learning Centers — Soaring Beyond Expectations

STUDENT INFORMATION

School: _____

_____ _____
Last Name First Name

_____ _____ _____
Grade Birthdate Teacher's Name

Reason for enrolling / Days child will attend Program:

- ☐ Teacher Referral
- ☐ Academic Help
- ☐ Work Schedule
- ☐ Other:

- ☐ Mon ☐ Tues
- ☐ Wed ☐ Thur
- ☐ Fri

PARENT/ GUARDIAN INFORMATION

PRIMARY (Parent/Guardian):

Name:_____
Relationship:_____
Address:_____
Primary Phone:_____
Place of Employment:_____
Work Phone:_____
E-Mail:_____

☐ *Child Lives at this address*

SECONDARY (Parent/Guardian):

Name:_____
Relationship:_____
Address:_____
Primary Phone:_____
Place of Employment:_____
Work Phone:_____
E-Mail:_____

☐ *Child lives at this address*

EMERGENCY CONTACTS

List other people authorized to pick up your child from program (Must be 14 or older and have identification):

Name:_____ Name:_____ Name:_____
Phone:_____ Phone:_____ Phone:_____
Relationship:_____ Relationship:_____ Relationship:_____

☐ *I authorize all individuals listed on the school emergency card for pick up*

MEDICAL INFORMATION

Check (x) any special medical condition that your child might have.

- ☐ Food allergies
- ☐ Non-food allergies
  Specify: _____
- ☐ Epi-pen for allergies
- ☐ Inhaler for allergies
- ☐ Inhaler for Asthma
- ☐ Epilepsy/Seizure disorder
- ☐ Diabetes

Other special/medical needs OR signs/symptoms to watch for medical conditions. Specify: _____
_____

Doctor Name:_____ Phone Number:_____

☐ Yes ☐ No **Will your child require medication at program?** If medications are necessary, a copy of the "Authorization to Administer Medication" form should be attached to this form.

OTHER

Does your child have an IEP? ☐ Yes ☐ No
Primary language of student?_____ Ethnicity:_____
Primary language of the parent/guardian?_____
Special concerns about your child or family - Specify? _____

AUTHORIZATION

☐ Yes ☐ No I hereby give my consent for my child to receive emergency medical care or treatment if I cannot be reached immediately.

☐ Yes ☐ No I will review the policies of this program and the guidelines by which the program is run and understand that it is my responsibility to assure that my child is present until the conclusion of any program day attended.

☐ Yes ☐ No I give my child permission to participate in fieldtrips and other off-site activities during program hours and that I will be notified in advance of these opportunities.

☐ Yes ☐ No I give my permission for my child to be photographed or videotaped for newsletters, website, and brochures.

☐ Yes ☐ No I give my child permission to participate in anonymous and/or confidential surveys and data for grants.

The number of eligible children seeking to enroll in the After School program often exceeds the number that may be safely & effectively served with available funding; therefore waiting lists may sometimes be established. Preference will be given to students who meet the grant criteria and attend program 5 days a week for the entire daily length of the program. Lack of transportation will not be a barrier to participation; contact Extended Learning at (920) 448-7548 regarding an application for transportation assistance.

Signature of Parent/Guardian_____

Relationship: ☐ Mother ☐Father ☐ Other _____ Date: _____

Office Use Only:
Start Date: _____ Start Date: _____
End Date: _____ End Date: _____