Save Our Children After-School Program
2019/2020 Registration Form

330 2nd St Elyria, Ohio 44035
(440) 323-3272

This form must be completed in full or it will not be accepted.

For any questions please contact our office.

Our mission is to change lives by improving literacy, cultivating leadership skills through mentoring, and promote academic excellence among at-risk youth in our community.

Date of Application: _____

PARTICIPANT INFORMATION: Please print clearly.

Child's Name: _____ M__ F__ Birth Date: _____ Age: _____

Address: _____ City: _____ Zip: _____

New Applicant to SOC? ___Yes, How Referred_____ ___No How many years at SOC? ___

Child's shoe size _____ Child's shirt size _____ Child's pants size _____

PARENT/GUARDIAN INFORMATION

Primary Parent/Guardian Name(s): _____ Relationship: _____

Home Address: _____ City: _____ Zip: _____

PHONES: Cell: (____) _____ Home: (____) _____ Work: (____) _____

Primary Parent's Email: _____

Secondary Parent/Guardian Name(s): _____ Relationship: _____

Home Address: _____ City: _____ Zip: _____

PHONES: Cell (____) _____ Home: (____) _____ Work: (____) _____

SCHOOL INFORMATION

School Attending: _____ Grade in Fall of **2019**: _____

Does your child have an IEP? _____

_____

ACADEMIC INFORMATION RELEASE STATEMENT

give permission for _____ (name of school) to release any information on my child's homework assignments, grades, progress reports, report cards, IEP, and state-wide testing assessments to the staff at Save Our Children of Elyria, Inc., in order to support my child's learning and academic growth. The school staff may also communicate with the SOC staff.

Parent/Guardian Signature: _____ Date: _____

MEDICAL/HEALTH INFORMATION FOR PARTICIPANTS: (REQUIRED)

Save Our Children staff will not store medications or administer medications to participants.

What medications is your child taking? _____

Are immunizations up to date? ___Yes ___No Date of last Tetanus: _____
Has your child had any injuries/illnesses/operations in the past year SOC? _____

Is your child currently under treatment or supervision? _____

Does your child have any food or seasonal allergies? _____

Does your child have restrictions in physical activities? ____ If so, why? _____

Are there any concerns that you would like to share concerning your child?

_____

_____

MEDICAL AUTHORIZATION: (REQUIRED)

In the event a child becomes seriously ill or hurt while he or she is under SOC supervision, a SOC staff will first notify the child's parent/guardian, then the child's physician. However, if the SOC staff is unable to locate such designees and considers immediate treatment necessary, then I, the undersigned parent/guardian, hereby authorize the staff at Save Our Children to take such emergency measures as seem reasonably necessary under the circumstances, including treatment and/or surgery by an available physician and/or in a nearby hospital.

Parent/Guardian Signature: _____ Date: _____

RELEASE OF CHILDREN

Please be advised that at SOC dismissal time, your child will be released to his/her parent/guardian or usual pick up person designated by the child's parent or legal guardian. If any other arrangements are desired or necessary, they must be communicated in advance and in writing to the SOC Office. Once the child has been released to the parent/guardian or authorized pick up person, Save Our Children will bear no further responsibility.

Please list below the names of adults other than parent/guardian whom you authorize to pick up your child.

First and Last Name of Adult	Relationship to Child	Age
_____	_____	_____
_____	_____	_____

Please list below the names of **ANYONE NOT ALLOWED** to pick up your child.

_____	_____	_____
_____	_____	_____

TRANSPORTATION: How will your child arrive at SOC? How will your child leave SOC?

If you can drive your child to and from SOC, please do. Our transportation vans have limited seating and make multiple trips; however, it is difficult to transport children who reside farther distances from SOC.

Please let us know how your child plans to <u>arrive</u> at SOC. (Check One)

____I will provide transportation for my child to SOC daily.
____My child will ride on the SOC van (if located within designated pickup area)

Please let us know how your child plans <u>depart</u> from SOC. (Check One)
***You may designate only one drop-off location for children. In case of an emergency please call SOC offices as soon as possible to notify our staff of the changed location.**

____I will provide transportation for my child home from SOC daily.
____My child with be transported on the SOC van.

Parent/Guardian Signature: _____Date: _____

ACKNOWLEDGEMENT OF RISK RELEASE

I understand that my child's participation in Save Our Children of Elyria, Inc.'s (SOC) programming is completely voluntary, and I have familiarized myself with the programs at Save Our Children of Elyria, Inc.

I understand that SOC shall not be responsible or legally liable for any bodily injuries or the result thereof incurred and suffered by my child on any property of SOC or while participating in any of SOC's activities. I understand that SOC cannot insure nor guarantee that the participants, equipment, premises and/or activities will be free of hazards, accidents or injuries. Furthermore, I recognize and have instructed my child in the importance in knowing and abiding by the program rules, regulations and procedures for the safety of all program participants.

Therefore, for myself, my spouse, and my child/children, I knowingly and voluntarily assume all risks involved in participating in the SOC program. I do hereby release, indemnify and hold harmless Save Our Children of Elyria, Inc., its members, trustees, officers, employees, independent contractors, and agents from injury, loss of life or personal property that may occur as a result of participating in SOC programs.

I have read, understand and accept all terms and conditions stated herein and acknowledge that this agreement shall be effective and binding upon the parties throughout the duration of participation of my child/children in the SOC programs.

FIELD TRIP AUTHORIZATION

My child has my permission to participate in all Save Our Children field trips.

I understand that a Save Our Children bus, van or vehicle contracted by the organization may be used for transportation on these trips.

In granting permission, I hereby release Save Our Children of Elyria, Inc., its employees, trustees, officers, agents, chaperones and the driver of the vehicle in which my child is traveling any liability connected with any of the trips. I further understand that by giving this permission, I need only notify Save Our Children of Elyria, Inc., in writing if I do not wish my child to participate in weekly field trips

INTERNET ACCESS

Supervised access to computers and the Internet will be granted to students. By signing below, you authorize your child to access the Internet responsibly with supervision of Save Our Children of Elyria, Inc., staff.

MEDIA RELEASE

I give my consent for SOC and persons acting through the organization to take, reproduce and/or distribute photographs films, videotapes, artwork, and sound recordings for printed and/or internet publicity.

I have read, understand, and accept all terms and conditions stated herein and acknowledge that this agreement shall be effective and binding upon the parties throughout the duration of participation of my child/children in the SOC program

Parent/Guardian Name: _____
(Please Print)

Parent/Guardian Signature: _____ Date: _____

FAMILY DEMOGRAPHIC INFORMATION

This information is used for the purpose of providing statistical information to Save Our Children funders. It is used anonymously, and no identifying information will be included in the reporting process. This information helps Save Our children to continue to offer high quality and FREE/LOW Cost programming and services.

RACIAL/ETHNIC BACKGROUND OF HOUSEHOLD

____Black/African American ____Caucasian ____Hispanic/Latino
____Asian/Pacific Islander ____Native American ____Other

TOTAL SIZE OF HOUSEHOLD (Adults and Children) No. of Adults ___ No. of Kids under 18 ___

(List ages of ALL Children in household under 18) _____

EMPLOYMENT/TRANSPORTATION/OWNERSHIP

How many adults in the household work? ____

How many adults work Full Time ____ How many adults work Part Time ____

How many kids in the household under 18 work? ___

Do you have access to reliable transportation? ___Yes ___No Do you own a car? ___Yes ___No

Do you own your home? **Yes No** Do you rent? **Yes No** Rent to Own? **Yes No** Rent Free? **Yes No**

PROGRAMS: Do you participate in the programs below: (Please check all that apply.)

___Work Experience Program (WEP)
___Training
___Job Search or other approved activity
___Free or Reduced Lunch for Children
___Transitional Work Program
___Public Assistance/Welfare
___Section 8 Housing
___Other

ANNUAL HOUSEHOLD INCOME: (Please check one.)

1. Under $5,000 _____
2. $5,000-7,499 _____
3. $7,500-$9,999 _____
4. $10,000-$14,999 _____
5. $15,000-$19,999 _____
6. $20,000-$29,999 _____
7. $30,000-$39,999 _____
8. $39,000-$49,999 _____
9. over $50,000 _____

EDUCATION

What is the highest level of education that the adults in the household have completed (write the relationship to child: mother, father, aunt, uncle, grandparent, etc.)?

Middle School _____
Junior High School _____
High School _____
GED _____
Some College _____
Associate degree _____
Bachelor's Degree _____
Other (list) _____

INDIVIDUAL CONSULTATION PARTICIPATION CONSENT AND RELEASE

As was discussed with you by your SOC Staff, _____ your child has been referred to a counselor from _____ OhioGuidestone who can assist in determining if mental health services may be beneficial to your child and, if so, what type of services would be most beneficial. In order to make this determination, the consultant from OhioGuidestone. would collect information from you, your child, and the school staff that know your child best. Some screening tools may be used to help make the best recommendations. After this information is collected, you will receive a call from Kaitilin Pratt who will explain the recommendations. If mental health services are recommended for your child and you wish to follow these recommendations, the ___ OhioGuidestone consultant will help to connect you with the right service.

These individual consultation services will be provided at no cost to the participant or family. This service is not a mental health assessment. Rather, it is a screening that is for the sole purposes of (1) identifying if mental health services are needed and (2) if so, making sure that you can connect your child to the needed service. Personal information or records obtained by the consultant from OhioGuidestone. will be kept secured and private.

Name of student _____ Name of Parent/Legal Guardian _____

Parent/Legal Guardian Phone Number: _____ Best time to call: _____

Emergency Contact Person (Name): _____ Phone Number: _____

Please provide the name of any school staff who could help the consultant better understand your child's needs: _____

Your signature will authorize your student to participate in the School Based Individualized Consultation Program.

Signature of Parent/Legal Guardian _____ **Date** _____

Signature of Student _____ **Date** _____ **Consultation**

Worker Signature _____ **Date** _____

CONSENT FOR RELEASE OF INFORMATION

Re (Student Name): _____ Date of Birth: _____

I, _____ (name), _____ (relationship) of

the above named student, hereby authorize OhioGuidestone, **the mental health agency providing School Based Services consultation services** Save Our Children , to share information & maintain records about the above named client with Save Our Children , for coordination of services. I understand that the Consent for the Release of Information expires at the end of the current school year unless otherwise indicated herein. I also understand that I may revoke this Consent for Release of Information at any time by stating in writing with the date and my signature and delivering it to **the School Based Services consultant from** OhioGuidestone. I recognize that if I revoke my consent, this does not include any information which has already been shared between the time that I gave permission to share information and the time it was cancelled. I understand that my signing or refusing to sign this consent will not affect services that I am eligible for. The information disclosed is in accordance with federal and state confidentiality rules; Federal regulation (42 CFR part 2) prohibits re-release of drug and alcohol information without specific written consent.

Signature of Parent/Legal Guardian _____ **Date** _____

Signature of Student _____ **Date** _____

SBS Worker signature _____ **Date** _____