



NIA After-School Program @ PS 30
2017 - 2018 School Year
Monday - Friday , 2:20 - 5:30PM

FAMILY REGISTRATION FORM

SHEET 1 OF 4

Child's Name _____ **Grade/Class** _____

Home

Address _____

Street

Apt#

City

State

Zip

Sex Female Male

Birth Date _____ / _____ / _____
Mo. Day Year

Age _____

Ethnicity

Asian Black/African American Hispanic/Latino Native American White Other

Siblings @ PS/IS 30

1. _____ Grade _____

2. _____ Grade _____

Parent/Guardian Information

(1) Name _____ Relationship to Student _____

Home Phone: _____

Cell Phone: _____

Business/Work Phone _____ Email Address _____

Best way to reach this person: _____

(2) Name _____ Relationship to Student _____

Home Phone: _____

Cell Phone: _____

Business/Work Phone _____ Email Address _____

Best way to reach this person: _____

Emergency Contacts & Authorized Pickup Persons:1st Contact/Pick Up Name: _____ Phone: _____

Relationship to the Child: _____

 Able to pick up this child[ren] in the family Not able to pick up the following child[ren] : _____

2nd Contact/Pick Up Name: _____ Phone: _____

Relationship to the Child: _____

 Able to pick up all this child[ren] in the family Not able to pick up the following child[ren]: _____I give my child permission to walk home alone at dismissal. YES NO

Parent/Guardian Signature

Date

1. Health/Insurance Information:

Child's Doctor: _____ Insurance Company: _____

Phone: _____ Policy Holder's ID: _____

Doctor's Address: _____

Allergies: _____ Last Tetanus: _____Medication(s) being
taken : _____Additional
Comments: _____

2. Health/Insurance Information:

Child's Doctor: _____ Insurance Company: _____

Phone: _____ Policy Holder's ID: _____

Doctor's
Address: _____

Allergies: _____ Last Tetanus: _____

Medication(s) being
taken : _____

Additional
Comments: _____

Emergency Medical Care

Child's Name: _____ Date of Birth _____

1. If my child requires emergency medical care and I cannot be reached, I give my consent to the NIA Program to obtain the necessary medical care for my child. I agree to pay all of the cost associated with the emergency medical care that my child receives. I understand that every effort will be made to contact me before and after medical care is provided.

2. Following emergency medical care, my child may be released to the following people:

Name _____ Relationship to child: _____

Address: _____

Home Phone _____ Cell Phone _____

Best way to reach this person: _____

3. I understand that this consent will be in effect as of the date of my signing this form and will continue as long as my child is enrolled in this program.

Parent/Guardian Signature

Date

Photo/Video/Interview Consent (To be completed by the parent or guardian)

I certify that I am the parent or legal guardian of _____, whose date of birth is _____.
 Name of child _____ month/day/year

I understand that this program features special events. Reporters and photographers may be present at these special events to record them. In some cases they may interview and/or photograph children who participate in these events. These photographs, videos, and interviews will only be used to promote this program and NIA.

I give permission for my child to be photographed or otherwise recorded during the NIA program events and activities, and for their name or likeness to be used by NIA in any medium (books, newsletters, web sites, etc.), whether now or hereafter known or developed.

Signature of Parent/Guardian

Date

I Do Not give permission for my child to be photographed or otherwise recorded during program events and activities. As a result, my child may not be able to participate in these events and activities.

Signature of Parent/Guardian

Date