AfterSchool Planet

# Summer Registration Form

**Office Use Only:**
R.A. _____ RCVD _____
C _____ CK _____ # _____ DT _____

Open to Children who are in One Year Old to 8th Grade during the month of September 2017
**January 2017 – May 15 2018 (Special Programs and snacks Included. Field Trips included)**

## Please complete all information as clear as possible (ONE form per family):

| | |
|---|---|
| Parent/Guardian's name | |
| Address: | |
| City: | |
| Email Address: | |
| Phone: | |
| Work/Cell Phone: | |
| Emergency Contact: | |
| Emergency Phone: | |

## Parent Work Information:

| | |
|---|---|
| Father's Employer's Name: | |
| Father's Employer's Phone: | |
| Father's Employer's Address: | |
| Mother's Employer's Name: | |
| Mother's Employer's Phone: | |
| Mother's Employer's Address: | |

| Participating child(ren)'s Name: | Child 1 | Child 2 | Child 3 | Child 4 |
|---|---|---|---|---|
| Sex: **Please circle** | Boy Girl | Boy Girl | Boy Girl | Boy Girl |
| Birthday/ Age | / | / | / | / |
| Grade in September: | | | | |
| Attending School District? | o Rosemead | o Rosemead | o Rosemead | o Rosemead |
| Indicate School Name: | o Temple City | o Temple City | o Temple City | o Temple City |
| | o Arcadia | o Arcadia | o Arcadia | o Arcadia |
| | o El Monte | o El Monte | o El Monte | o El Monte |
| English Proficiency | Please circle one: | Please circle one: | Please circle one: | Please circle one: |
| | o Fluent<br>o Good<br>o Not Preferred | o Fluent<br>o Good<br>o Not Preferred | o Fluent<br>o Good<br>o Not Preferred | o Fluent<br>o Good<br>o Not Preferred |

**I give permission to my child to attend Programs at AfterSchool Planet and authorize for EMERGENCY medical treatment.**

AfterSchool Planet

# Summer Registration Form

**Office Use Only:**
R.A. _____ RCVD _____
C _____ CK _____ # _____ DT _____

Should it be necessary for my child to have medical treatment while participating in programs on premises, I hereby give the person in charge permission to act on my behalf to secure hospitalization or medical services deemed necessary and appropriate by the physician. I hereby authorizes the principal or designee, into whose care the student has been entrusted, to consent to any X-ray examination, anesthetic, medical or surgical diagnosis, treatment, and/or hospital care to be rendered to the student upon the advice of any license physician and/or dentist. It is understood that this authorization is given in advance of any required diagnosis, treatment, or hospital care and provides authority and power to the AfterSchool Planet to give specific consent to any and all such diagnosis, treatment, or hospital care which a license physician or dentist may deem necessary. This authorization is given in accordance with Section 49407 of the California Education Code, and shall remain effective until revoked in writing and delivered to the AfterSchool Planet director. I absolve said AfterSchool Planet and its personnel from any and all forms of negligence and wrong treatment incurred in the procurement and process of hospitalization and medical treatment. All cost incurred for paramedic transportation, hospitalization, and any examination, X-ray, or treatment provided in relation to this authorization shall be my sole responsibility as the student's parent/gardian.

**HEALTH ALERTS** - List any medical condition which restricts physical activity or requires special attention. Include conditions such as asthma and allergies such as peanut and bee stings. If none, please indicate "NONE".

_____

**HEALTH INSURANCE** - Does the student have health insurance? ___Yes ___No (please list information below)

**MEDI-CAL HEALTHY FAMILIES ID NUMBER** -_____

**PRIVATE HEALTH INSURANCE NAME** - _____ GROUP NO:_____

**NAME OF DOCTOR/MEDICAL OFFICE**: _____ PHONE NO: _____

**MY CHILD IS ALLERGIC TO THE FOLLOWING MEDICATIONS**:

_____

**MY CHILD CURRENTLY TAKES THE FOLLOWING MEDICATIONS**: _____

_____

Client Information - for purpose of data collection, we like to ask the following demographic information, mark all that apply:

Racial Background Information:
Single Categories:
_____ American Indian / Alaska Native
_____Asian
_____Black / African American
_____Native Hawaiian / Other Pacific Islander
_____White, Caucasian

Ethnic Background:

_____Not Hispanic / Spanish / Latino
_____Mexican / Mexican American / Chicano
_____Puerto Rican
_____Cuban
_____Other Hispanic / Spanish / Latino
_____Two or More _____

Housing Demographics Information:
Area Categories:
_____ Arcadia
_____ Duarte
_____ Rosemead
_____ Temple City
_____ San Gabriel
_____ Pasadena
_____ El Monte
_____ Monrovia
_____ West Covina
_____ San Marino
_____ Other

**I CERTIFY THAT I HAVE READ AND UNDERSTOOD THIS FORM AND DO HEREBY GIVE MY AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT, AND THAT ALL OF THE INFORMATION I HAVE PROVIDED ON THIS FORM IS TRUE AND CORRECT.**

Signed: _____ Date:_____

*(Parent or Guardian's Signature)*