ROSCCO BEFORE AND AFTER SCHOOL ACTIVITIES PROGRAM REGISTRATION /EMERGENCY FORMS

____DAVENPORT RIDGE ____HART MAGNET ____K.T. MURPHY ____NEWFIELD
___NORTHEAST ____ROGERS INTERNATIONAL ___ROGERS@ Strawberry Hill
____ROXBURY ___JULIA A. STARK ___SPRINGDALE ___STILLMEADOW
____TOQUAM MAGNET___WESTOVER MAGNET

Before School Program____ After School Program____ Circle Years in Program 1 2 3 4 5 6

Child's Name:____ Male ______ Female ________
Child's Birthday___________________________ Child's age:__________Grade_______
Room#/Teacher:____
Address:____Zip:__________Phone:_________________

List names of father and/or mother. (Or Guardian if applicable.)
Name:____Relationship______________________
Home Address:____ Home Phone________________________
Stamford, CT. ________Cell Phone/Pager______________________ E-MAIL __________________________
Place of Employment:____
Address:____
Occupation____Work phone:______________________

Name:____Relationship______________________
Home Address:____ Home Phone________________________
(only if different from above)Cell Phone/Pager _____________________ E-MAIL ________________________
Place of Employment:____
Address:____
Occupation____ Work phone :__________________________

Registration for the Month(s) ________________________________Fee to be paid: Monthly_____Term______

BEFORE SCHOOL PROGRAMS 5 DAYS starts at 7:30 a.m.______
(ROGERS ONLY) Extended a.m. begins at 6:00 a.m.______

(Option for After school Programs ONLY)
5 DAYS A WEEK______4 DAYS A WEEK___3 DAYS A WEEK___ (Begins at school dismissal and ends at 5:30 p.m.).
PLEASE SPECIFY DAYS: M-F ______MONDAY___TUESDAY___WEDNESDAY___THURSDAY__FRIDAY
Rogers (Both Locations) 5 Day Option only: Extended p.m. begins at school dismissal and ends at 6:00 p.m.___

Does your child have any health conditions, allergies or special concerns we should know about? NO____ Yes____ If you answered yes, please list the conditions on Page 2 of this registration form section.

FOR OFFICE USE ONLY: **Start Date_______________**

Received _______ Processed _____ Nurse's Review ______ Data Base _____ Copied_______

Withdrawal Date **Reason**

ROSCCO REGISTRATION/EMERGENCY FORM Page 2

ROSCCO BEFORE PROGRAM_____ AFTER SCHOOL PROGRAM_____School______________

NAME OF FATHER________________________ MOTHER______________________________
PHONE: Home____________________________ PHONE: Home__________________________
Work ___________________________________ Work_________________________________
Cell/Pager_______________________________ Cell/Pager______________________________

CHILD'S NAME: ________________________________Birthday____________________________

Written Plan for Accident/Illness Emergency

1. Staff will contact parent or other authorized adults regarding illness. A child who is ill or is not feeling well must be picked up from the program.
2. In the case of an accident/emergency, certified staff will assess situation, call 911, administer First Aid/CPR and call the parent or authorized adults to notify them of the accident/emergency.
3. If 911 is called the child will be taken to the hospital via ambulance.
4. Parents or authorized person should be present at the hospital for any medical attention to be given to the child. Authorized adults include child's physician, relatives, friends, etc.

List two people we can phone in case of emergency when the parents cannot be reached. (The persons listed below are also authorized to pick-up my child.)
1. Name:____Relationship_________________________
Phone (Home)_____________________________________(Work)______________________________
2. Name:____Relationship________________________
Phone (Home)_____________________________________(Work)______________________________
STAMFORD HOSPITAL will be used for all local emergencies. The nearest hospital will be used when on field trips.
NAME OF CHILD'S PHYSICIAN & PHONE:____

Please list your child's health conditions, allergies or other concerns that we should know about?

Does your child need medication for the condition? No____ Yes____ If yes, does your child need emergency medication at ROSCCO? NO____YES____ If you responded YES, you must provide ROSCCO with a completed Medication Authorization Form and an Emergency Health Care Plan issued by your child's physician before your application is complete and a start date issued.

I__________________________________(parent's name) understand that in case of emergency, first aid will be administered and the parents or other designated responsible individuals will be notified. I give permission to the **ROSCCO** staff to obtain emergency medical treatment for my child. I understand **ROSCCO** is not responsible for the cost of emergency treatment or for medical care given by emergency medical personnel. I also understand that all expenses incurred are the responsibility of the parent.
INSURANCE CARRIER:_____________________________POLICY#______________________

Signature:_______________________________________Date:______________________________

ROSCCO BEFORE AND AFTER SCHOOL ACTIVITIES PROGRAM
REGISTRATION/EMERGENCY FORM Page 3

CHILD'S NAME:________________________________SCHOOL__________________________

HOMEWORK

_____ If my child has homework, my child is required to do it at **ROSCCO**. I understand that it is my child's responsibility to indicate that he/she has assigned homework and that scheduled supervised homework time is approximately 30 - 40 minutes daily.

______My child is not required to do his/her homework at **ROSCCO**. I do understand that my child will be offered an alternate quiet activity during group homework time (reading, table games, puzzles).

AUTHORIZATION TO PICK-UP

Parents/guardians and persons listed as emergency contacts are authorized to pick-up my child. The following is a list of additional persons to whom **ROSCCO** is authorized to release my child.

NAME **RELATIONSHIP TO CHILD** **PHONE NUMBER/CELL**

1. ____

2. ____

3. ____

4. ____

______I understand that I or an adult whom I have designated above will be responsible for picking up my child promptly by the end of the After School Activities Program at 5:30 p.m. I understand that there will be a surcharge of $1 per Minute for children who are picked up after 5:30 p.m. and that this fee is due by the end of the week which the Late Pick-Up occurred.

SCHEDULED OFF-SITE FIELD TRIPS

_______ I hereby give my permission for my child to participate on scheduled off-site ROSCCO Field Trips. I understand that the field trips will be listed on the Monthly Calendars issued to parents. I also understand that all Field Trips will be supervised by ROSCCO staff and transportation will be via School Bus.

_______ I do not give my child permission to participate on scheduled off-site ROSCCO Field Trips. I understand that my child will not participate in the ROSCCO Program on Scheduled Field Trip days and that I will pick up my child at school dismissal.

ON-SITE FIELD TRIPS_______ I understand that on-site field trips to other areas in the school building will be scheduled as needed due to shared school building space use.

ACKNOWLEDGEMENT

I acknowledge that I have received a copy of the ROSCCO Parent Handbook and understand the program policies and procedures. Furthermore I acknowledge that the techniques used to manage child behaviors have been discussed with me and that these will be reviewed with me as needed during my child's enrollment in the ROSCCO Programs.

PARENT/GUARDIAN SIGNATURE:__________________________________DATE:_________

ROSCCO MEDICAL RELEASE FORM

SCHOOL___________________

ROSCCO BEFORE PROGRAM______ AFTER SCHOOL PROGRAM_____

CHILD'S NAME:_____________________________GRADE ___CLASSROOM_____________

NAME OF FATHER______________________ MOTHER_____________________________

RE: PHYSICALS AND IMMUNIZATIONS:

I understand that state law requires that licensed school age child care programs maintain a medical record, including proof of immunizations, for each child enrolled. I understand that it is the parent's responsibility to provide these medical records and emergency medication if required by doctor's orders. I understand these records are a registration requirement of the ROSCCO Programs and will be kept on file as part of my child's registration information.

In addition, I authorize the ROSCCO Executive Director and/or Director of Before and After School Activity Programs to communicate with the school nurse of my child's school. Further, I authorize the School Nurse to communicate to the ROSCCO Executive Director and/or Director of Before and After School Activities Program any medical concerns regarding my child's health.

Signature of PARENT/GUARDIAN________________________________Date____________

ROSCCO MEDIA RELEASE FORM

From time to time we are visited by media representatives (newspapers, local television stations, etc). The following grants permission for your child to participate in media coverage relating to the **ROSCCO** Before and After School Programs when the occasion arises.

I give______ do not give______my son/daughter/ward _________________________________
permission to participate in a filmed or taped TV/radio/video interview for broadcast or photograph for newspaper/magazine/book publication and/or ROSCCO web page.

I understand this participation will be related to the **ROSCCO** Program in which my child is enrolled.

Signature of PARENT/GUARDIAN________________________________Date____________

STATISTICAL INFORMATION Page 5

From time to time we are required to furnish statistical information. The following are questions that we ask you to answer. The information on this form is confidential and will be used only to administer our programs and for aggregate statistical information.

Today's Date:_____________________ Enrollment Date:__________________

Parent's Name____

Relationship to participant: (circle) self, mother, father, guardian, relative, other______________

Child's Name____Birth date__________Sex______

Ethnicity/National Background:_______________Primary Language (if not English)______________

Parent's highest grade in school or college completed: (circle highest)

High school — K 1 2 3 4 5 6 7 8 9 10 11 12
College — 1 2 3 4 Graduate/Professional

If applicable, highest grade in school or college spouse/partner completed: (circle highest)

High School — K 1 2 3 4 5 6 7 8 9 10 11 12
College — 1 2 3 4 Graduate/Professional

How did you hear about ________________ the program you are enrolling in?

___newspaper/television/radio(circle)
___friend/neighbor
___referred by state agency
___called ROSCCO Office
___school publicity
___relative
___referred by child care provider
___referred by other FRC service
___Other____

Family income: $0-$15,000____ $15,000-$30,000_____ $30,000-$45,000_____
$45,000-$60,000____ $60,000-$75,000_____ $75,000 above_______

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ACCEPTANCE

I have read the **ROSCCO 2018-2019** Before and After School Parent Handbook regarding the program philosophy, program policies, general program operations and financial policies.

I understand all the information and conditions of my child's registration and accept them while my child is enrolled as a participant in the programs.

____ ____________________

Signature Date

Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel .

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student ________________________________ Date of Birth____/____/____ Today's Date____/____/____

Address of Child/Student ____Town__________________

Medication Name/Generic Name of Drug_______________________________________ Controlled Drug? YES NO

Condition for which drug is being administered: ____

Specific Instructions for Medication Administration ____

Dosage_____________________________Method/Route______________________________________

Time of Administration ________________________ If PRN, frequency_____________________________

✦ **Medication shall be administered: Start Date: _____/_____/_____ End Date: _____/_____/______**

Relevant Side Effects of Medication ____ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs____

Plan of Management for Side Effects ____

Prescriber's Name/Title ____ Phone Number (_____) ______________

Prescriber's Address ____ Town __________________

✦ **Prescriber's Signature** ____ Date _____/_____/_____

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Parent/Guardian Authorization:

- ✓ I request that medication be administered to my child/student as described and directed above
- ✓ I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication.
- ✓ I have administered at least one dose of the medication with the exception of emergency medications to my child/student without adverse effects. (For child care only)

✦ **Parent/Guardian Signature**__________________________________ Relationship______________ Date ____/____/____

Parent /Guardian's Address ____Town__________________State_____

Home Phone # (_____) ______-________ Work Phone # (_____) ______-________ Cell Phone # (_____) ______-_______

******************** **SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL** *****************

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: ☐YES ☐NO ______________________________________ ____________
Signature Date

Parent/Guardian authorization for self-administration: ☐YES ☐NO _____________________________________ ___________
Signature Date

STAFF approval for self-administration: ☐YES ☐NO ____ ____________
Signature Date

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✦ Today's Date ______________ Printed Name of **ROSCCO STAFF** Receiving Written Authorization______________________

Date _____________ Printed Name of **Site Coordinator** Receiving Medication_______________________________________

✦ ____ **Site Coordinator Signature**