

Coalition For Kids, Inc. Enrollment Form

Student Name: _____
(Last) (First) (Middle)

Gender: () Male () Female Race: _____

Home Address: _____ City _____

State: _____ Zip: _____ County: _____

Mailing Address (if different): _____

Home Phone: _____ Cell Phone: _____

Father's Name: _____ Phone:(H) _____ (W) _____

Mother's Name: _____ Phone:(H) _____ (W) _____

Stepfather's Name: _____ Phone:(H) _____ (W) _____

Stepmother's Name: _____ Phone:(H) _____ (W) _____

Guardian's Name: _____ Phone:(H) _____ (W) _____

Custody: () Mother () Father () Joint () Other Resides With: _____

If Parents cannot be reached call:

1. Name: _____ Address: _____

Phone: (H) _____ (W) _____ Relationship: _____

2. Name: _____ Address: _____

Phone: (H) _____ (W) _____ Relationship: _____

Do not release this child to _____. (see court papers in record)

Father's Employer: _____ Address: _____

Days at Work: ()M ()T ()W ()T ()F Hours: _____

Mother's Employer: _____ Address: _____

Days at Work: ()M ()T ()W ()T ()F Hours: _____

Custodial Family Income: \$0 - \$24,499 ___ \$24,500 - \$39,999 ___ \$40,000 - & over _____

School: _____ Address: _____ Phone: _____

Grade Entering: _____ Shirt Size: _____

Date of Birth: _____ Social Security #: _____

Are you eligible for Child Care Certificate? () Yes () No

Does your child qualify for a lunch program: ___free ___reduced ___neither

Transportation: () Coalition Bus () Parent Pick up

Program Enrolled In: () Community Kids Activity Club Attending Summer School: Yes No

Date Enrolled in Program: _____ Date Exiting Program: _____

Days Attending Program: () M () T () W () TH () F

I _____ hereby give my consent for my child to be transported & supervised by the Coalition For Kids, Inc. staff on field trips and to other programs not conducted on "The Rock" grounds. If my child rides any form of transportation provided by the Coalition For Kids, Inc., I understand that I must be PRESENT and VISIBLE in order for the driver to release my child from the van. **Initial:** _____

I have been informed of the Coalition For Kids, Inc. policy regarding pick-up times, fees, late pick-up fees, extended care hours, transportation and emergencies and fully understand and agree to these policies. **Initial:** _____

Siblings attending Coalition For Kids, Inc. program:

1. _____ School: _____ Grade: _____

2. _____ School: _____ Grade: _____

3. _____ School: _____ Grade: _____

A copy of my child's immunizations and health records stating that they are up-to-date are currently on file at their school. () Yes () No

The following are authorized to pick up my child or my child may be dropped off to this person if riding The Rock van (other than custodial parents or guardians).

1. Name: _____ Address: _____

Phone: (H) _____ (W) _____ Relationship: _____

2. Name: _____ Address: _____

Phone: (H) _____ (W) _____ Relationship: _____

Special Services

Yes No My child may receive emergency medical care and I agree to assume all expenses for moving and medical treatment. I consent to any treatment, surgery
() () diagnostic procedure, or the administration of anesthesia as may be deemed necessary by the physician. (Life-threatening situations, only)

Yes No My child may have his/her work displayed or have a photograph placed in Coalition For Kids, Inc. publications and on the Coalition For Kids web site, or
() () other public media such as newspaper.

Yes No I grant the Coalition For Kids, Inc. access to school records and to contact my child's teacher, administrator, guidance counselor, caseworker, therapist, or
() () physician for further information regarding the participant's limitations and the most effective plan for providing the agency's recreation and educational
services. **All information will be kept confidential.**

Parent Signature: _____ **Date:** _____

MEDICAL INFORMATION

Physician's Name: _____ Address: _____ Phone: _____

Does your child suffer from:

Asthma _____ Special Instructions: _____

Diabetes _____ Special Instruction: _____

Seizure Disorder _____ Special Instructions: _____

Allergies: _____ What type? _____ Special Instructions: _____

BEE STING:

() Local reaction only; red, swollen at sight.

() SEVERE reaction; difficulty breathing, life threatening, etc.

Procedure for Bee Sting:

1. _____

2. _____

Other Medical Problems/Comments:

**ALL MEDICATION MUST BE SENT FROM HOME IN ORIGINAL CONTAINER WITH MEDICATION FORM SIGNED BY PARENT
(AND PHYSICIAN, IF PRESCRIPTION)**

My child is enrolled in or has been enrolled in anger management, special education or other classes. () Yes () No

Please explain: _____

Insurance Information:

Carrier: _____ Policy Number: _____

I hereby release and discharge the Coalition For Kids, Inc., its staff, and Board of Directors from any liability or civil damages in regard to the giving of said consent to any hospital or licensed personnel.

Signed: _____

Date: _____