



Coalition For Kids, Inc.
Summer Enrollment Form

For office use only:
Complete Incomplete
Student ID# More information required
Site Director Initials

Child's Name (Last) (First) (M.I.)

Gender: () Male () Female Race: Date of Birth: / /

Social Security # - - School:

Grade Entering Fall 2019: T-Shirt Size: Youth: S 6/8 M 10/12 L 14/16
Adult: S M L XL 2XL

- 1. Does your child qualify for a lunch program? () Free () Reduced () Neither
2. A copy of my child's immunizations and health records stating that they are up-to-date and are currently on file at their school. () Yes () No
3. Are you eligible for DHS Families First Child Care Certificate? () Yes () No () Maybe

Program Enrolled: Summer ()

Date Enrolled in Program: / /

Siblings attending Coalition For Kids, Inc. Program: (please enter Fall 2019 information)

- 1. Name: Grade: School:
2. Name: Grade: School:
3. Name: Grade: School:
4. Name: Grade: School:

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:

I give my permission for Coalition For Kids Inc. to relay information regarding my child's behavior and/or important memos to the Authorized Pick-Up. () Yes () No
If no, please list who cannot receive information:

Guardian's Name (Last) (First) (M.I.)

Address:

City State: Zip County

Mailing Address (if different):

Phone (Home) (Cell)

Email Address:

Father's Name: Phone: (1) (2)

Authorized Pick-Up () Yes () No

Mother's Name: Phone: (1) (2)

Authorized Pick-Up () Yes () No

Stepfather's Name: Phone: (1) (2)

Authorized Pick-Up () Yes () No

Stepmother's Name: Phone: (1) (2)

Authorized Pick-Up () Yes () No

Mother's Employer: Hours:

Days at Work: () M () T () W () Th () F Address:

Father's Employer: Hours:

Days at Work: () M () T () W () Th () F Address:

Custody () Mother () Father () Joint () Other Resides with

Custodial Family Income: \$0-24,999 \$24,500-39,999 \$40,000-& Over

Do not release this child to (see court papers on file)

If parents cannot be reached call:

1. Name: Authorized Pick-Up () Yes () No
Phone (H) (C) Relation

2. Name: Authorized Pick-Up () Yes () No
Phone (H) (C) Relation

3. Name: Authorized Pick-Up () Yes () No
Phone (H) (C) Relation

Medical Information

Physician's Name _____

Address: _____ City _____ State _____ Zip _____

Phone: (____) _____

Does your child suffer from any of the following?

Asthma: ()Yes ()No **Special Instructions:**

Diabetes: ()Yes ()No **Special Instructions:**

Seizure Disorder: ()Yes ()No **Special Instructions:**

Allergies: ()Yes ()No **If so, what type?** _____

Special Instructions: _____

Can your child be exposed to the allergen? _____

Bee Sting: () Local reaction (red, swollen at sight) **Procedure for bee sting:**

() **SEVERE reaction** (difficulty breathing, life threatening, etc.) **Procedure for bee sting:**

Other Medical Problems/Conditions or Comments:

(ALL MEDICATION MUST BE SENT FROM HOME IN ORIGINAL CONTAINER WITH MEDICATION FORM SIGNED BY PARENT. ALL PRESCRIPTION MEDICATION MUST BE IN ORIGINAL CONTAINER WITH MEDICATION FORM SIGNED BY A PHYSICIAN.)

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

If so, please explain:

Special Services

1. ()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)***

2. ()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, Inc. web site, or other public media such as a newspaper.

3. ()Yes ()No I grant the Coalition For Kids, Inc. access to school records, grades, TNReady scores and to contact my child's teacher, administrator, guidance counselor, caseworker, physician for further information regarding the participant's limitations and the most effective plan for providing the agency's recreation and educational services. I also would like for Coalition For Kids to sit in on IEP meetings that will benefit the direction of my child's success. ***(All information will be kept confidential.)***

Guardian Signature: _____ **Date:** ____/____/____

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.

Guardian Signature: _____ **Date:** ____/____/____