



## STUDENT INFORMATION

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Gender: Male Female What Grade Is Student In: \_\_\_\_\_ Student School: \_\_\_\_\_  
Shirt Size: YS: 6-8 YM: 10-12 YL: 14-16 AS AM AL AXL Other \_\_\_\_\_ Student Age: \_\_\_\_\_

## PARENT/GUARDIAN INFORMATION

Mother/Guardian Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
\_\_\_\_\_  
Address: City, State Zip  
\_\_\_\_\_  
E-mail: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
\_\_\_\_\_  
Father/Guardian Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
\_\_\_\_\_  
Address: City, State Zip  
\_\_\_\_\_  
E-mail: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
\_\_\_\_\_

## Emergency Contact/Authorized Pick-up Information (in addition to names listed above)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

## LIABILITY INFORMATION

**CONSENT FOR MEDICAL TREATMENT** As the parent or legal guardian of the above-named child, I hereby give my consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb, or well being of my dependent.

**RELEASE OF LIABILITY** In consideration of their child being permitted to participate in any event or activity sponsored, promoted, or organized by the Hammond Afterschool Program, the undersigned for himself or herself, personal representatives, heirs, assigns, relatives, and minor child hereby releases, the Hammond Afterschool Program, and its respective insurers, officers, officials, sponsors, and employees, hereafter referred to as RELEASES, of any and all liability to the minor child, whether the child is for any purpose participating in such event or activity. It is fully understood by each of the undersigned that there is some inherent risk associated with the activity, including damages to property and personal injury. In addition, the undersigned agrees to indemnify and hold harmless the releases of any loss, liability damage, or cost they incur due to such participation by the child, whether caused by releases' negligent act or omission, acts or omissions of other participants, other persons or otherwise while the minor is participating in any event or activity organized and/or sponsored by the Hammond Afterschool Program. In signing this release, I hereby acknowledge and represent to the Hammond Afterschool Program the following:

1. That he/she has read the Foregoing Release and Waiver of Liability and Indemnity Agreement and fully understand its contents.
2. That his/her minor child participating in the event or activity is in good health, physically fit, and physically able to participate in the activity.

**IMAGE CONSENT/RELEASE** I hereby give permission for images of myself and the child for whom I am guardian that are captured during the Hammond Afterschool Program's activities or events through video, photo, and digital camera to be used for purposes of documentation, promotion, and publicity of the program and its associated activities and waive any rights of compensation or ownership thereto. As such, I relieve and hereby agree to hold the City of Hammond, Hammond Afterschool Program, affiliated organizations, and sponsors or partners of the City of Hammond Recreation Department free and harmless from any and all liability arising out of interviews, footage, or photography and subsequent publication or broadcast. I understand that the recording/interviews/photography are being carried out with my consent, and so I assume full responsibility.

By submitting this registration form, you understand and agree to all registration policies.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## AFTER SCHOOL HEALTH HISTORY FORM

Please list any medications/allergies that may need attention during afterschool program hours:

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Please describe any dietary modifications or considerations:

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Name of physician and contact information:

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Hospital preference:

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Name of Insurance: \_\_\_\_\_ (or circle if Medicaid)

Policyholder: \_\_\_\_\_

Policy Number: \_\_\_\_\_ (please attach a copy of insurance card)

This health history is correct, as far as I know, and the person herein described has permission to engage in all prescribed activities except as noted. I hereby give permission to the medical personnel selected by the coordinator to order routine tests, x-rays, treatment and necessary transportation for the individual named above. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the coordinator to secure and administer treatment, including, hospitalization, for my child named above.

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Parent/Guardian Signature

Date

### ***The Healthy School Food Collaborative***

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. To file a program complaint of discrimination complete the [USDA Program Discrimination Complaint Form](http://www.ascr.usda.gov/complaint_filing_cust.html), (AD-3027) found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html),

- ◆ Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339 or [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html).

- 1) Mail: U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410;
- (2) Fax: (202) 690-7442; or
- (3) Email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

# IMPORTANT INFORMATION

## PROGRAM INFORMATION

Program begins **September 11, 2017**

and ends **May 11, 2018**

**Monday through Thursday: 3:00pm — 6:00pm**

**Friday 3:00 pm – 5:30pm**

Registration is open to 3rd - 8th graders. Those in Kindergarten - 2nd grade are welcome to attend if their older siblings are enrolled in the program.

Fridays are recreational days, but private tutoring is available for a small fee. Please inquire if interested.

## REGISTRATION FEES

- ◆ \$20.00 Weekly - Cash, Check, Money Order (Partial fees are not accepted)
- ◆ **\$200 per semester if paid in full**
- ◆ Make check payable to:  
**City of Hammond Recreation**
- ◆ Financial assistance is available
- ◆ **Fees paid are non refundable**

## MEAL/SNACK

- ◆ Snacks are served daily at **Arrival**.
- ◆ Meals are served daily at 5:15pm.
- ◆ Snacks and meals are included in the registration fees.

## ENROLLMENT AGREEMENT

I understand that I must sign my child out of the program daily, and I must provide a valid picture identification in order to do so. Any other authorized persons sent to pick up my child must be listed on the child's application and must also be able to furnish a picture identification.

- **Attendance is Required for all children receiving financial aid. Five (5) unexcused absences may result in financial aid probation or termination from Afterschool.**
- **I understand that my child must be picked up daily by 6:00. Late pick-ups will result in a fee of \$1 per min . Three (3) late pick ups may result in termination from the program.**

## TRANSPORTATION

Daily bus transportation will be provided by the Tangipahoa Parish School System from your child's school to the Kenney Recreation Center. Parents are responsible for picking up children by 6:00pm unless the children are riding the bus home.

**No students are allowed to walk to the Kenney Recreation Center. All students must be dropped off either by bus or parent/guardians.**

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Official Only**

**Fee Paid: \_\_\_\_\_**

**Received F/A [ Y ] [ N ]**