



Latitude Collaborative

Community Scholars
Enrollment Form

LATITUDE COLLABORATIVE

2017-2018 After-School Program

CHILD INFORMATION

Child's Full Name: _____

Age: _____ Birthdate: _____ Sex: _____

School Child Attends: _____ Enrolled Grade (as of 8/17/17): _____

FAMILY INFORMATION

Father's Name: _____

Father's Address and Primary Phone Number:

Father's Email: _____

Mother's Name: _____

Mother's Address and Primary Phone Number:

Mother's Email: _____

Does child live at above address? Yes No

If no, please provide child's address: _____

How many adults live with the child? _____

Please provide names and ages of siblings or other children who live with the child:

HEALTH INFORMATION

Does the child take any prescribed medications? ___ Yes ___ No

If yes, please list medications: _____

Will any medication need to be administered during the hours of the Community Scholars program?

___ Yes ___ No (If yes, please complete the "Authorization to Administer Medication Form")

Does the child have a history of serious illness or exhibit any of the following health concerns?

(Please check all that apply)

___ Allergies & Immune System (celiac, food allergies, lactose intolerance, etc.)

___ Asthma

___ Blood (anemia, sickle cell, etc.)

___ Brain & Nervous System (autism, epilepsy, etc.)

___ Diabetes

___ Heart & Lungs (cystic fibrosis, heart murmurs, etc.)

___ Infections (chronic ear infections, lyme disease, HIV/AIDS, prone to developing strep throat, mono, etc.)

___ Learning & Emotional (ADHD, Hyperactivity, OCD, eating disorder, dyslexia, separation anxiety, etc.)

___ Sight, Speech & Hearing (blindness, requires glasses, deafness, requires hearing aides, stuttering, etc.)

Please elaborate on any items checked above and provide a description regarding any health concerns we should be aware of. Explain how the health concern might impact the child's participation and describe necessary cautions and care needed.

MEDICAL AUTHORIZATION & EMERGENCY CONTACTS

In the event that emergency treatment is needed, I understand that Latitude Collaborative will use the contact information provided on this form to immediately notify the parent(s)/guardian(s) when emergency medical attention is necessary. I understand that if the parent(s)/guardian(s) cannot be reached, Latitude Collaborative will begin notifying the emergency contacts listed on this form using the contact information provided. If no contact is able to be reached, I understand that Latitude Collaborative will not transport my child for necessary medical care; however, a representative of Latitude Collaborative will accompany my child by ambulance to receive medical care and remain with my child until I can be reached.

I request that the following individuals be contacted in the event of an emergency and I authorize each of the following individuals to assume temporary care of my child if I am unable to be reached. Please list individuals in the order you want them to be reached in the event of an emergency.

Name	Relationship to Child	Phone Number
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1. _____

2. _____

3. _____

Parent/Guardian Signature: _____

Parent/Guardian Printed Name: _____

Child's Name: _____ Date: _____

TECHNOLOGY RELEASE PERMISSIONS

Latitude Collaborative has my permission to use my or my child's photograph publically to promote the Community Scholars program or other related programs offered by the organization. I understand that the images and/or video may be used in print publications, online publications, presentations, websites, and social media. I also understand that no royalty, fee or other compensation shall become payable to me by reason of such use.

Parent/Guardian Signature: _____

Parent/Guardian Printed Name: _____

Child's Name: _____ Date: _____

CHILD PICK-UP RELEASE PERMISSIONS

Please list the name of each individual who has permission to pick-up this child from the Community Scholars program or other related programs offered by Latitude Collaborative. Parent/Guardians names should also be listed. The child will not be released to any individual who is not listed on this form.

The following individuals have my permission to pick up this child from the Community Scholars program:

Name	Relationship to Child	Phone Number

Parent/Guardian Signature: _____

Parent/Guardian Printed Name: _____

Child's Name: _____ Date: _____

ATTENDANCE INFORMATION

Please check the days of the week that your child will attend Community Scholars. Each child will be required to attend a minimum of three consistent days per week; however, it is recommended that your child attend every day. Strong attendance ensures that your child is benefiting from all offerings and will also help your child to better acclimate to the program, staff, expectations and routine.

DAY	DAYS ATTENDING
MONDAY	
TUESDAY	
WEDENSDAY	
THURSDAY	
FRIDAY	

Registration forms may be submitted at any time; however, a \$25 registration fee is required per child, per semester and must be received before your child will be officially enrolled into Community Scholars.