

# INNOVATIONS

## EXTENDED CARE PROGRAM

### 2010-2011 Student Participation Form

STUDENT INFORMATION			
Please print and complete this entire section about your child:			
1. Last Name (LEGAL NAME) <small>Suffix (Jr, II, III)</small>		First	Middle
			Grade Level:
2. Nickname:		3. Other name(s) used previously (AKA):	4. Birth date:  / /
5. Gender:	6. Age:	7. Ethnicity:	8. Home phone #: ( )
9. Household address: Zip code:		City, State:	
SIBLING INFORMATION			
Complete this section, if applicable. Include only siblings who are currently in Grades K-8 participating in program.			
Sibling 1 Legal Name:			Grade:
Sibling 2 Legal Name:			Grade:
Sibling 3 Legal Name:			Grade:
Sibling 4 Legal Name:			Grade:
CONTACT INFORMATION			
Please complete this entire section. You must provide information for three contacts.			
	ENROLLMENT PARENT, GUARDIAN OR FOSTER PARENT	OTHER PARENT, GUARDIAN OR FOSTER PARENT	EMERGENCY CONTACT OTHER THAN PARENT OR GUARDIAN
Contact Full Name			
Relationship to Student		Authorized to pick up child: Yes / No	Authorized to pick up child: Yes / No
Lives with Student (circle one)	Yes / No If no, provide address here:	Yes / No If no, provide address here:	Yes / No If no, provide address here:
Home Phone	( )	( )	( )
Work Phone	( )	( )	( )
Cell Phone	( )	( )	( )
Email Address			
Employer			

<b>Primary Language</b>			
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<b>Last Name (LEGAL NAME ONLY)</b>	<b>First</b>	<b>Middle</b>	<b>Grade Level:</b>
<b>ADDITIONAL EMERGENCY CONTACT INFORMATION</b>			
Please list additional adults authorized to pick up child from program and to be contacted in case of emergency.			
<b>Name</b>	<b>Address</b>	<b>Telephone</b>	<b>Relationship</b>
1			
2			
3			
<b>STUDENT'S HEALTH HISTORY INFORMATION</b>			
Innovations Extended Care Program operates on the school campus; however, your child's health information cannot be shared between the school and extended care program. To ensure that Innovations Extended Care provides a physically and emotionally safe environment for your child, please fill in all necessary information and attach documents if needed.			
1. Is your child under regular supervision by a physician?		Yes      No	Date of Last Exam:
2. Does your child currently have asthma, diabetes or a medical condition that requires him/her to receive medication or health procedures at school?		Yes      No	If Yes, please describe:
To request that Innovations Extended Care staff administer medication to your child while attending Extended Care, you must complete the "Authorization to Administer Medication Form" available from program leader.			
3. Please list any allergies, dietary restrictions or physical activity limitations:			
4. Specify any other illness, injury, social/emotional needs or medical condition which Innovations Extended Care staff should be made aware of:			
Please complete questions 5-9. Check Yes or No for each question. If yes, Innovations Extended Care Program Director will be calling you to discuss proper accommodations if needed.			
5. Does your child currently receive Special Education services?		Yes      No	If yes, please identify any accommodations needed:
6. Does your child receive additional one-on-one support during the regular school day?		Yes      No	7. Parent/Guardian's evaluation of child's health:
8. Does your child have a 504 plan?		Yes      No	If yes, please identify any accommodations needed:
9. Does your child receive nursing services during the school day?		Yes      No	If yes, please describe:
10. Please list any special accommodations or needs your child may require in order to participate in the current level of supervision (student to staff ratio is 15:1 at Innovations Extended Care):			
11. Parent/Guardian's evaluation of child's personality:			
12. Does your child have any special fears or challenges?			

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**INSURANCE INFORMATION**

1. My child has medical insurance coverage with (insurance co., Medi-Cal):  
Policy # \_\_\_\_\_ Phone # \_\_\_\_\_ Policyholder's Name (please print) \_\_\_\_\_
2. My child has medical insurance coverage with (insurance co., Medi-Cal):  
Policy # \_\_\_\_\_ Phone # \_\_\_\_\_ Policyholder's Name (please print) \_\_\_\_\_
3. My child does not have medical/dental insurance coverage at this time (this will not affect participation in Innovations Extended Care Program).

**PHYSICIAN AND/OR DENTIST CONTACT INFORMATION**

Please list physician and/or dentist to be contacted in case of emergency:

Name	Address	Telephone	Doctor/Dentist
1			
2			

**SAFETY POLICY**

As part of our commitment to maintain a safe environment for your child(ren) Innovations Extended Care requires that every student is properly signed in upon entry to the program and signs out upon exiting the program each day. We support the parents decision on how you would like to see this policy met by placing a check next to the appropriate box below:

- Before Care**
- My child must be signed in by the adult dropping them off in the morning.
  - My child is allowed to sign themselves in when they arrive at the Innovations before care program.
- After Care**
- My child must be picked up by an authorized adult listed on the Emergency Contact Information (photo ID and signature is required).
  - My child is allowed to sign themselves out when they are leaving the Innovations after care program.

I understand that Innovations Extended Care Program is not liable for incidents involving my child which occur before and/or after his/her authorized arrival and/or departure time.

Parent/Legal Guardian/Foster Parent Signature:	Date:
Program Leader Signature:	Date:

## 2010-2011 Student Participation Form

Last Name (LEGAL NAME) Suffix (Jr, II, III)	First	Middle	Grade Level:
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### PARENT/GUARDIAN/FOSTER PARENT ACKNOWLEDGEMENT

Please read the following carefully and acknowledge your agreement by signing below.

#### Liability Release

- Innovations Extended Care does not maintain health insurance for injuries to the participant that may arise from involvement in Innovations Extended Care.
- I agree to inform my child that he/she must follow all school and program rules.

#### Program/Student Evaluation

- I hereby give my consent for Innovations Extended Care staff to discuss my child's academic and behavior progress with school personnel to determine areas of need. I understand that information about my child's progress in school, as well as surveys given to parents, teachers, and administrators, may be used to evaluate the program and that those data shall remain confidential and my child's name shall not be released or identified under any conditions.

#### Photo/Video/Media Release

- During the school year, schools will hold events that the news media, the Innovations Extended Care Program may like to feature. A representative may be on campus to gather photographs and/or video footage highlighting the event and featuring Innovations students. We value your child's participation, and ask for your permission to include him or her. Please indicate by checking the box(es) below whether your child has your permission to participate:
  - I give my permission to have my child interviewed and photographed/videotaped by the news media.
  - I give my permission to have my child photographed by the Innovations Academy or Innovations Extended Care. Photos may be used on Innovations Academy website.
  - I give my permission to have my child be videotaped by the Innovations Extended Care. Videos may be viewed by District staff or the public.
  - I give my permission to have the Innovations Extended Care feature my child's school work using first name only (e.g. art, essays, etc.). Work may be displayed on IA website.
  - Please **do not** include my child in these activities. I **do not** want my child photographed or videotaped.

#### 2010-2011 Innovations Extended Care Parent/Guardian Handbook

- I have received, read, and agree to abide by the policies and procedures included in the 2010-11 Innovations Extended Day Care Program Handbook.
- I understand that it is my responsibility to keep all information current.

In signing below, I acknowledge and I am in agreement with the Liability Release, Authorization For Emergency Medical Treatment, Program/Student Evaluation, Photo/Video/Media Release (checked box(es) only) and the 2010-11 Innovations Extended Care Parent/Guardian Handbook.

Parent/Legal Guardian/Foster Parent signature:

Date:

### BEFORE AND AFTER SCHOOL SCHEDULE

Program Hours of Operation	Before School: Start Time: <u>7:00 AM</u> End Time: <u>School Start Time</u> After School: Start Time: <u>School Release Time</u> End Time: <u>6:00 PM</u>
Check Program	Before and After Program                      Drop Off Program Only Before School Program Only                      After School Program Only
Check Days that Apply	Monday    Tuesday    Wednesday    Thursday    Friday

<b>Parent/Legal Guardian/Foster Parent Signature:</b>	<b>Date:</b>
<b>Program Leader Signature:</b>	<b>Date:</b>