Family Network After School Activity Program (ASAP)

2017-2018 Consent Form and Emergency Contact Information

Child's Name: ___________________________ **Birth date**: _____/______/______ **Sex**: Male Female

Address: ________________________________ **City**: _______________________ **Zip**: ____________

School Attending (circle one): Indian Trail | Lincoln | Oak Terrace | Ravinia | Wayne Thomas | Red Oak | Sherwood

Grade in 2017-2018 School Year: ____

Enrolled for (circle days): Monday Tuesday Wednesday Thursday Friday

Parent/Responsible Party		Parent/Responsible Party
	Name	
	Relationship to Child	
	Home Phone	
	Business Phone	
	Cell Phone	
	Email Address	
	Home Address	
	Business Address	
	Working Hours	

Legal Guardian: ________________________Work Phone: _______________________Cell Phone: _________________
Step Parent: ___________________________Work Phone: _______________________Cell Phone: _________________

EMERGENCY and RELEASE INFORMATION: The following information is for use in case of emergency and for everyday pick-up release information. We will attempt to notify parents first. Please list people approved to pick-up your child during the program hours. **Please complete all sections.** Contact us with any changes in writing. In case of serious illness, parents will be called and instructed to meet their child and a staff member at the nearest hospital.

Child ***CAN*** be released to (Please list individuals **other than parents/legal guardian** and step parent listed above):

Name	Relationship to Child	Address	Phone (Home & Cell)
1.			( ) ( )
2.			( ) ( )
3.			( ) ( )
4.			( ) ( )

Child ***CANNOT*** be released to (proof of court order required):

Name	Relationship to Child	Address	Phone
1.			( )
2.			( )
3.			( )

I give permission for my child _______________ to receive emergency medical treatment which may include, but is not limited to, first aid by staff, care by paramedics, physician or local hospital. I understand that I am responsible for any costs incurred.

____ ____

Signature Date

____ ____

Print Name Relationship to Child

Doctor(s) Name/Practice: ____Phone: _____________________________________

Address: ____ Hospital Affiliation___________________________

Child's Dentist ____Phone: ______________________________________

I have informed the ASAP director and staff of all medical and emergency information pertaining to my child. I give permission to the school nurse to provide a copy of the emergency medical information for my child.
(Please Print) Student Name: ____

Parent Signature: ____ **Date** ______________________________________

Allergies (include food, medication, insects, etc.): ____

____

Any additional physical/mental health information or other special needs including academic deficits:

____

____

PHOTO
I give the Family Network After School Activity Program (ASAP) permission to use photos of (student name) ____________________or other family members (parent and sibling names) ____________________________________ in publications or for publicity informational purpose. I understand that Family Network owns rights to the photos.

EXCURSIONS and Field Trips
I/We authorize ASAP staff or agents to take my child/ren on walking trips, excursions and field trips. They may travel in any vehicle leased by ASAP. I understand that I will receive notification prior to any fieldtrip and have the right to refuse authorization for my child to go on the fieldtrip.

RELEASE OF LIABILITY FOR MINORS
I understand that Family Network's After School Activity Program (ASAP) is attempting at all times to exercise reasonable caution and I do not hold them responsible for accidental injury occurring while my child is attending the program. I hereby expressly forever waive, release and discharge the Family Network After School Activity Program (ASAP) and their representatives from all such liabilities, claims, demands, injuries, damages, rights of action, or cause of action, whether the same be known or unknown, anticipated or unanticipated.

____ ____

Guardian Signature One Date

____ ____

Print Name Relationship to Child

____ ____

Guardian Signature Two Date

____ ____

Print Name Relationship to Child

Return to: Bobbie Hinden, ASAP Director
Family Network | 330 Laurel Avenue | Highland Park, IL 60035
Email: bobbie.hinden@family-focus.org | Phone: 847.433.0377 Fax: 847-433-0461