safe places, linked hearts
fihankra akoma ntoaso

Program Enrollment Form

CONTACT INFORMATION

Participant Information

Name: _____
First MI Last

Gender: Male Female

DOB: _____
Month Day Year

Address _____
Number and Street Apt. #

_____
City State Zip

Telephone (home): _____

Telephone (cell): _____

School Name: _____

School Phone: _____

School Contact Name: _____

School address: _____
Number and Street

_____
City State Zip

Current Grade: _____

Dismissal Time: _____

Caregiver Information

Name:

First Last

Work Address:

Number and Street Suite.
#

City State Zip

Telephone (home):

Telephone (work):

Telephone (cell):

Telephone (other):

Name:

First Last

Work Address:

Number and Street Suite.
#

City State Zip

Telephone (home):

Telephone (work):

Telephone (cell):

Telephone (other):

Caseworker Information

Name:

First Last

Agency Name:

Address:

Number and Street Suite.
#

City State Zip

Telephone (work):

Telephone (cell):

E-mail:

Name:

First Last

Address:

Number and Street Suite #

City State Zip

Telephone (home):

Telephone (work):

Telephone (cell):

Telephone (other):

HEALTH INFORMATION

Insurance Information

Insurance Carrier: _____

Policy Number: _____

Address: _____

_____

Phone: _____

Physician Information

Name: _____

Address: _____

_____

Phone: _____

General History

This participant has had chicken pox or received the varicella immunization	☐ Yes	☐ No
This participant has NOT had mononucleosis (mono) during the past school year	☐ Yes	☐ No
This participant's hearing is within normal ranges	☐ Yes	☐ No
This participant's sight is within normal ranges or s/he uses corrective lenses to remedy vision	☐ Yes	☐ No
This participant is free of illness, injury, or physical challenges that would affect program participation	☐ Yes	☐ No

Please provide additional information about any marked “no” above:

_____

_____

_____

_____

Allergies

☐ The participant has no known allergies

☐ The participant is allergic to the following foods: _____

☐ This participant is allergic to the following medications: _____

☐ Other Allergies: _____

For any allergies indicated above, please describe the reaction and what is done to manage it:

_____

_____

_____

Immunization History

Immunization	*Date (month/year)*	*Immunization*	*Date (month/year)*
Tetanus Booster*	Within 10 years:	MMR (Measles, Mumps, Rubella)*	
Varicella (chicken pox)		Polio*	
Meningitis		Pneumoccocal	
Pertussis Booster (Whooping Cough)	Recommended Update at 12 years:	DPT (Diptheria, Tetanus, Pertussis)*	
Hepatitis B		Hepatitis A	
Influenza			

*Must be up to date

Chronic Health Concerns

☐ This participant has no chronic health concerns

☐ This participant has the following chronic health concerns:

☐ Asthma	☐ Headaches	☐ Diabetes
☐ Menstrual Cramps	☐ Fainting	☐ Seizure disorder
☐ Frequent colds	☐ Surgical history of consequence	☐ Sickle cell
☐ Immune deficiency	☐ other	

Please provide additional information about items checked above:

Mental, Emotional, and Social Health

This participant has been diagnosed with Attention Deficit Disorder (ADD) or ADHD	☐ Yes	☐ No
This participant has a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder	☐ Yes	☐ No
This participant has an emotional health concern	☐ Yes	☐ No
During the past academic year, this participant has seen or is currently seeing a professional to address mental/emotional concerns	☐ Yes	☐ No

Please provide additional information about items checked above (triggers, behavior programs, etc):

Medication

☐ This participant will not take any medications during program hours

☐ This participant will take the following medications during program hours:

Name of Medication	Reasons for taking it	Doses and when given	Date Started

AUTHORIZATION & RELEASE

Hold Harmless: In consideration of allowing this child to participate in FAN Youth Programs and to the fullest extent permitted by law, I agree to hold harmless FAN, its trustees, officers, directors, employees, agents, volunteers and assigns from and against all claims arising out of or resulting from my child's participation in FAN Youth Programs. "Claim" as used in this agreement means any financial loss, claim, suit, action, damage, or expense, including but not limited to attorney's fees, attributable to bodily injury, sickness, disease or death, or injury to or destruction of tangible property including loss of use resulting therefrom. In addition, I hereby voluntarily hold harmless FAN, its trustees, officers, directors, employees, agents, volunteers and assigns from any and all claims, both present and future, that may be made by the participant, me, my family, estate, heirs or assigns.

I hereby expressly agree to hold harmless FAN, its trustees, officers, directors, employees, agents, volunteers and assigns for any claim arising out of or incident to my child's participation in FAN Youth Programs, unless caused by the sole negligence of FAN.

Consent to Arrange Emergency Treatment: I understand and acknowledge that on rare occasions an emergency may develop which necessitates the administration of medical care, dental care, hospitalization or surgery to the participant named above. Therefore, in event of injury or illness to this participant which necessitates emergency medical or dental care, I hereby authorize FAN, its staff in charge of FAN Youth Programs, to arrange any necessary emergency treatment including the administration of anesthetics and surgery to this participant. In the event of injury or illness that does not necessitate emergency medical care, I understand that FAN Youth Programs and FAN do not have facilities for the care of ill children.

Travel Authorization: I hereby grant permission to the agents of FAN Youth Programs to transport this participant on scheduled field trips.

Please check all that apply:
□ This participant may be picked up from the program by the following individuals:

Name: _____ Phone: _____

Name: _____ Phone: _____

□ This participant may sign him/herself out of the program and travel home alone

□ This participant may leave the program by FAN provided transportation

□ This participant may leave the program on DCPS provided transportation

I understand that the ability of program staff to properly supervise participants may be impaired when students are not under their direct control. I agree that FAN should not be held accountable when students are authorized to use alternative means of transportation. I understand that the program staff and the organization will be released from responsibility if a participant violates his/her caregiver's above stated choices.

Authorized signature: _____ Date:_____

Printed Name: _____
Relation to participant: _____

Permission to Use Photography, Likeness or Names: I hereby give permission to FAN to use this child's photographic image and/or name, in whole or in part, for FAN Youth Programs-specific public information and marketing activities at the discretion of FAN.

Authorized signature: _____ Date:_____

Printed Name: _____Relation to participant: _____

TRANSPORTATION REQUEST FORM

Transportation is a very expensive and limited resource. As part of our effort to make sure that we can make the best possible arrangement for as many participants as possible, please answer the following questions:

Yes	No	Does this participant have permission to travel to the program by public transportation or on foot?
Yes	No	Does this participant use CFSA or agency transportation to travel to and from school?
Yes	No	Is there someone who could bring this participant to the program from school?
Yes	No	Is there someone who could bring this participant home from the program at the end of the day?

☐ This participant will only be able to participate if FAN provides transportation to the program at the start of the afternoon.

Pick up address: _____

Number and Street Apt. Number

_____

City State zip

Pick up phone: _____

☐ This participant will only be able to participate if FAN provides transportation home at the end of the program day:

Drop off address: _____

Number and Street Apt. Number

_____

City State zip

Drop off phone: _____

We will do our best to accommodate as many participants as possible on FAN transportation. We appreciate your assistance in arranging alternative transportation if possible. Any participant traveling by FAN transportation to the program at the start of the program day **must alert the office by 12:00 PM** if s/he will not be attending program that day. Transportation is limited, and will be offered based on need.

Check List

- ☐ Contact information (pp. 1-3)
- ☐ Health Information (pp. 4-7)
- ☐ Release/Authorization Form (p. 8)
- ☐ Transportation Request (p.9)
- ☐ 2012-2013 Report Card