

2022-2023 CSI Out of School Time Activity Registration Form



SCHOOL: _____

Student Name (1): _____ **Date of Birth:** _____ **Grade:** _____

Student Name (2): _____ **Date of Birth:** _____ **Grade:** _____

Student Name (3): _____ **Date of Birth:** _____ **Grade:** _____

Student Name (4): _____ **Date of Birth:** _____ **Grade:** _____

Primary Contact Information:

Parent/Guardian Name: _____ **Relationship to Child:** _____

Does child live with this individual? Yes No Part-time

Address: _____ **Zip:** _____

Primary Phone: _____ **Secondary Phone:** _____

Email Address: _____ **Preferred Contact:** Call Email Text

Secondary Contact Information:

Parent/Guardian Name: _____ **Relationship to Child:** _____

Does child live with this individual? Yes No Part-time

Address: _____ **Zip:** _____

Primary Phone: _____ **Secondary Phone:** _____

Email Address: _____ **Preferred Contact:** Call Email Text

Emergency Contact: *Should you not be available please tell us who to contact in case of an emergency.*

Contact Name: _____ **Relationship to Child:** _____

Primary Phone: _____ **Secondary Phone:** _____

Email Address: _____ **Preferred Contact:** Call Email Text

Do you give permission for child to be released to this person? Yes No

Additional child release contacts:

Please identify any additional people authorized to pick up your child from the OST program activities (including friends or siblings). Contacts must have photo ID. Additional names can be added on a separate sheet of paper.

Name(s): _____



CHECK IN AND OUT FOR OUT OF SCHOOL TIME ACTIVITIES:

Please see your school program supervisor for detailed check in and out policies.

FIRST AID & EMERGENCY MEDICAL CARE

Family physician/clinic: _____ Phone: _____

Health Insurance Provider: _____ Policy Number: _____

Does the student(s) take medications? Yes No

If yes, please specify which student(s) and what medications: _____

Does your child(ren) require any medical or behavioral accommodations? Yes No

If yes, please specify which student and what accommodations are required: _____

Are these **formal ADA Accommodations** Yes No?

If yes, the school will be contacting you to set up a meeting to discuss further.

APS Notice of Equal Opportunity and Reasonable Accommodation:

In compliance with Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. Sec.706(8)): "No qualified individual with a disability shall, solely on the basis of his or her disability, be denied participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

1. All out of school time activities, including before/after school programs, in APS schools provided by the school and/or private individuals and organizations, including programs through the Community School Initiative (CSI), must be provided in a manner as is necessary to afford qualified students with disabilities an equal opportunity for participation.
2. All out of school time activities, including before/after school programs, in APS schools provided by the school and/or private individuals and organizations, including programs through the Community School Initiative (CSI), must offer reasonable modifications and provide those aids and services that are reasonably necessary to ensure an equal opportunity for the qualified students with disabilities to participate. This may include an Educational Assistant, a 1-on-1 aide, an interpreter, or other service provider if it is determined during an individualized inquiry that the student requires it.
3. The District is obligated to conduct an individualized inquiry regarding the disabled student's needs. Although the District makes the final determination as to what is reasonably necessary to ensure an equal opportunity for qualified students with disabilities to participate in after school activities, the District is obligated to involve the student's parents/guardians in the individualized inquiry process.

For more information contact the APS Compliance Officer:

Office of Equal Opportunity Services, Phone: (505) 855-9831 or Email: EOSoffice@aps.edu

Website: Office of Equal Opportunity Services

Does your student(s) have allergies, special diets or chronic health conditions? Yes No

If yes, please specify which student and what allergies etc.: _____



PARENT/GUARDIAN PERMISSIONS SIGNATURE PAGE:

Please initial each box below, complete the student's name section, sign, and date.
Return this form as directed by school staff.

Emergency Care: I authorize staff and volunteers of the CSI Out of School Time program who are trained in the basics of first aid to give my child(ren) first aid when appropriate. I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child(ren). However, if I cannot be reached, I hereby authorize APS out of school time program staff to request transport my child(ren) via emergency service (911) to the nearest medical facility and to secure necessary medical treatment for my child(ren). I will not hold the program responsible for accidents or injuries that may occur, and I agree to be responsible for any charges incurred in the rendering of medical care and treatment for my child.

Photograph/Video: I hereby give permission for my child's unidentified image (electronic, video, still) to be used in connection with the activities of CSI Out of School Time program and to be used in newspaper and magazine articles, video and television productions and other presentations related to the program. This includes student intellectual property such as artwork, poetry, essays, performances, or other work product directly related to the OST program activities my child(ren) participates in.

Behavior: I understand that program staff and volunteers are responsible for maintaining a safe educational environment and if my child(ren)'s behavior is disruptive or in violation of the school rules for student behavior that s/he may be dismissed from any activity in accordance with school/district policies. I also understand that my child(ren) will be provided a pathway to rejoin the CSI Out of School Time program activities.

Data Collection: I understand that the CSI Out of School Time program activity leaders will be tracking my child(ren)'s name and activity attendance and that my child(ren) will be required to complete a satisfaction survey at the end of each program/activity session. I understand that this data will be shared with the ABC Community School Partnership staff. All data shared for program reporting and quality assessment purposes will be deidentified when shared beyond APS or ABC staff.

I, the parent/guardian of the students listed in the above registration form and listed below, agree to the above stated permissions, and allow my child to participate in the CSI Out of School Time Program.

1. Student Name: _____
2. Student Name: _____
3. Student Name: _____
4. Student Name: _____

Parent/Guardian Signature

Date

