



# Community Connections Registration Form 2024-2025

Student's Name \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_\_\_ Grade (24-25) \_\_\_\_\_

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School \_\_\_\_\_ E-mail Address \_\_\_\_\_

*(Please provide your e-mail as this is our primary contact method)*

Student's Address \_\_\_\_\_

Street

Town

State

Zip

1. Name of Parent/Guardian \_\_\_\_\_

Phone (h) \_\_\_\_\_ Phone (w) \_\_\_\_\_ Phone (c) \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

2. Name of Parent/Guardian \_\_\_\_\_

Phone (h) \_\_\_\_\_ Phone (w) \_\_\_\_\_ Phone (c) \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

Second household Email: \_\_\_\_\_

With whom do the children live? \_\_\_\_\_

How will your children get home after Community Connections activities?

Picked up \_\_\_\_\_ Walk home \_\_\_\_\_ Other \_\_\_\_\_

☆ **What information can you share with us to help us best meet your child's needs?** \_\_\_\_\_

\*\*\*MUST Complete Below Area with at least 2 non-parent contacts, they may be the same as the emergency contacts on the back:

**Pre-authorized Alternative Pick-up Individuals:** Safety is our top priority; no child will be released from the program without a **parent/guardian signature** or that of one of the 3 individuals listed below *(the names listed must be of someone 16 years or older)*:

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

▶ I give permission for the school nurse to share my child's immunization/medical records with CC personnel.  
 yes  no

▶ I understand photographs or videos may be taken for publicity purposes or newsletters. I give permission for my child's image to be used.  yes  no

▶ I understand some of the programs are off school grounds. I give permission for my child to leave school grounds and be transported if necessary. I will receive prior notice of any such off school plans  yes  no

▶ I give permission for surveys to be given to my child and his/her family for purposes of program evaluation.  
 yes  no

▶ I give permission for CC staff to apply sunscreen to my child.  no  yes *(Family will provide a sunscreen)*  
 yes *(School Sunscreen may be used)* **Brand** \_\_\_\_\_, we may or may not be able to make this available to you, it is always best for you to send some from home and label it with your child's name.

**Return this form to your school's Site Coordinator, or scan to: [kbolduc@u32.org](mailto:kbolduc@u32.org) "[kbolduc@u32.org](mailto:kbolduc@u32.org), or mail to: WCUUSD-Community Connections, 1130 Gallison Hill Rd., Montpelier, VT 05601-0155.**

Student Start Date: \_\_\_\_\_

## Medical Information

Does your child(ren) have any allergies? (*food, drug, insect, etc.*) \_\_\_ Yes\* \_\_\_ No \*If yes, please describe:

Child's name and allergies: \_\_\_\_\_

Child's name and allergies: \_\_\_\_\_

Child's name and allergies: \_\_\_\_\_

Does your child(ren) have: (*Please check ALL that apply, give child's name*)

\_\_\_ Contact lenses \_\_\_ Glasses \_\_\_ Seizures \_\_\_ Asthma \_\_\_ Heart trouble \_\_\_ Other (*specify*)

How do you treat/control the condition?  
\_\_\_\_\_

★ **Are there any social, emotional, behavioral, or health conditions that we should be aware of? What might we find helpful in creating a successful day for your child?**  
\_\_\_\_\_  
\_\_\_\_\_

Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Date of child's most recent physical or well child exam: \_\_\_\_\_

Is your child(ren) currently taking any medication? \_\_\_ Yes \_\_\_ No

If yes, child's name & description: \_\_\_\_\_

2nd child's name & description: \_\_\_\_\_

3rd child's name & description: \_\_\_\_\_

Does this medication need to be given during program time? \_\_\_ Yes\* \_\_\_ No

*\*If yes, you must contact the Site Coordinator before your child starts the program.*

## Release

I hereby give permission for my child(ren) to participate in Community Connections Programs. I assume all risks and hazards incidental to such participation, including transportation to and from activity. I hereby waive, release, absolve, indemnify, and agree to hold harmless Community Connections and Washington Central UUSD, their officers, agents, officials, employees and volunteers, the organizers, sponsors, supervisors and participants for any claim arising out of an injury to my child.

## Emergency Contact

*(you MUST list two non-parent contacts)*

In the event of an emergency, if I cannot be contacted, I authorize the following persons to act on my behalf:

**Emergency Contact #1** \_\_\_\_\_

Relationship \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_

**Emergency Contact #2** \_\_\_\_\_

Relationship \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_

## Medical Release

In the event that my child(ren) is injured or needs medical help I understand that hospital personnel will attempt to contact me before administering treatment to my child. I authorize Community Connections staff to obtain emergency medical care for my child from a hospital or physician at my expense, this may include medical transport. I understand I will be notified first if at all possible.

**Signature of Parent or Guardian:** \_\_\_\_\_ **Date** \_\_\_\_\_