





#### 2019-2020 T.R.A.C.K.S. PROGRAM REGISTRATION PACKET

T.R.A.C.K.S. SITE LOCATION:	Date:
Student's Full Name:	
Birth Date: Age	Grade:
Race: American Indian, Asian, Black, White	Ethnicity: No, Not Hispanic Yes, Hispanic
Home Address:	
Mailing Address:	
Father's Full Name:	Phone:
Father's Employer:	Phone:
Mom's Full Name:	Phone:
Mom's Employer:	Phone:
Student lives with Mom, Dad, Both Parents	, Other
Legal Guardian:	Phone:
List any medical concerns/health problems: Alle	rgies, etc.

#### 2019-2020 T.R.A.C.K.S. PROGRAM

Emergency Contacts (other than the parents, in case of accident or illness) These people are allowed to pick up your child, if you are unable to pick them up. If a person is NOT on the list, he/she will not be able to pick up your child. We will call the parents at the number listed above first.

	Name	Relationship	Phone Number
		to Student	
1.			
6.			
7.			
8.			
Sp	ecial Legal/Custo	dy Restrictions:	

## 2019-2020 T.R.A.C.K.S. PROGRAM

#### Permission Waiver

Child's Name	Parent/Guardian Signatur	e Date
I have received a co T.R.A.C.K.S. Progra	py of the Parent Handbook and ag m policies.	ree to the Franklin County
<ul> <li>If you move or chaimmediately.</li> <li>We do not wish to additions, or deletichild.</li> </ul>	be disruptive or be a threat to themselves of inge your home/cell phone numbers, please be intrusive, but we must be kept apprised ons to the student's daily sign-out release for yone who picks up your child to bring a p	notify your After-School Supervisor of changes in guardianship, custody, orms as it relates to our care for your
	Signature of Parent/Guardian	Date
- ·	t1st Century AfterSchool/Summer program t sportation, for my child if I cannot be reache al expenses incurred.	
S	ignature of Parent/Guardian	Date
Program events, activities enrichment activities. I gi	for my child to participate in the 21st Century, and field trips. This may include pre/post two permission for my child's work or photosermission for the 21st Century Staff to have a	tests, surveys, access to the Internet and to be used in program implementation

## 2019-2020 T.R.A.C.K.S. PROGRAM (Fall Semester & Spring Semester ONLY) Homework & Attendance Policy

The continuation of funding for this program is based largely on your child's academic improvement and attendance. Therefore, the program takes an aggressive approach regarding the completion of assigned homework, project and daily attendance. The following procedures have been established to ensure all requirements related to academic achievements and attendances in the grant are achieved.

#### **Academic (Homework/Assignments):**

- Students are required to bring homework assignment sheets or bring assignments written in a notebook or a newsletter from his/her teacher(s).
- If students have no assigned homework, they will be expected to do other academic/enrichment activities assigned, during homework time.
- After 2 consecutive days of "no homework" in a subject area, the TRACKS staff will check with your child's classroom teacher(s) to verify homework assignments.
- The TRACKS program does not replace the place of parental academic support. Parents
  need to check their child's/children's homework assignments for completion and accuracy. If
  students have tests that students are expected to study at home, then parents should review
  the skills/content with their child/children.

#### Attendance:

- Your child/children are required to meet in the designated area for after-school program.
   If your child is NOT going to attend on a given day, please notify the after-school program staff that he/she will not be attending that day.
- (IMPORTANT) Students are required to attend the TRACKS program a minimum of 4 days a week.

I agree to abide by the attendance procedures for the program as stated above.

Parent/Guardian Signature

Student(s) Name(s)



# ALABAMA STATE DEPARTMENT OF EDUCATION Franklin County T.R.A.C.K.S. Program



	<b>HEALTH</b>	<b>ASSESSMENT</b>	<b>RECORD</b>
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	1854 RTMENT OF EDUCATION OF EDU
hool Year:	

To Parent or Guardian:

The purpose of this form is to provide the school nurse with additional information regarding your child's health needs. The school nurse may contact you for further information. The information requested is essential for the school nurse to meet the health needs of your child.

#### This information will be kept confidential.

Name of Student (Last, First, Middle)			Birth Date	e Sex	School	
I					ļ	
Address (Street)						
Home Telephone Number:	Cell Phone	Numbor:	Additional Phone	Numbor:	Grade	Teacher/Homeroom
iome Telephone Number.	Cell I Hone	rivarriber.	Additional Filone	ivaniber.	Grade	If Known
Name of Parent/Guardian (Last	, First Middle	e)				Work Phone Number:
Transportation If known						
□ Bus Rider Bus Number:	□ C	Car Rider	□ Speci	al Needs Bu	JS	□ After School
		Part I	– Health Inform	mation		
Place your child receives health	care:	Your child's	Insurance Information	n:	Place your child receives dental care:	
Physician's Name:			Dentist's Name:			
Address:		Address:				
Phone:		Phone:				
□ Community Health Center □ Other		☐ Community Health Center				
☐ Health Department ☐ Private Insurance ☐ Health Department			Department			
☐ Hospital Clinic					☐ Hospit	al Clinic
□ No Regular Place □ No Regular Place		gular Place				
□ Private Doctor /HMO □ Private Dentist /HMO		e Dentist /HMO				
Preferred Hospital:						
Part II – Med	dical His	tory Medic	al Equipment /	Procedu	ıres Req	uired at School
Catheter	Tube	<ul> <li>Nebulizer</li> </ul>	Treatments □	Oxygen	Suppleme	nt   Tracheostomy
Vagal Nerve Stimulator	(VNS)	□ Ventilator	□ Wheelchair	□ Wa	alker	
□ Other <i>Please explain:</i>						



# ALABAMA STATE DEPARTMENT OF EDUCATION Franklin County T.R.A.C.K.S. Program HEALTH ASSESSMENT RECORD



~		
School	Year:	

Name of Stud	ent	Part III – Medical History				
□ YES □ NO						
	If NO, go directly to the bottom of the page and pro		signature			
	If YES, and diagnosed by a physician, answer each	ch question below.				
□ YES □ NO	Attention Deficit Disorder (ADD)					
□ YES □ NO	Attention Deficit Hyperactivity Disorder (ADHD)					
	Requires medication					
□ YES □ NO	Allergies:	□ Hives/rash	□ Medications			
	□ Food					
	□ Insects	□ Breathing difficulty	□ Epi-pen			
	□ Environmental □ Medications	□ Other:				
□ YES □ NO	Asthma Uses an inhaler at school	☐ Uses an inhaler at h	nome			
l IL3 l NO	Astrilla Uses arrillialer at scribbi		ione			
□ YES □ NO	Blood/Bleeding Problems: □Hemophilia,	□Von Willebrand's,	□Other			
	Requires medication Please explain:					
□ YES □ NO	Frequent Nose Bleeds: Please explain					
□ YES □ NO	Cancer/Leukemia: Please explain					
□ YES □ NO	Cerebral Palsy: Please explain					
□ YES □ NO	Cystic Fibrosis: Please explain					
□ YES □ NO	Dental Problems: Please explain:					
□ YES □ NO	Diabetes □ Type 1 Diabetes □ Monitors Blood Su	ugars at school	□ Requires Insulin at school			
			□ Insulin pump			
	- Time 2 Diabates - Managed with disp		□ Glucagon order			
	□ <b>Type 2 Diabetes</b> □ Managed with die	I .	□ Oral medication			
□ YES □ NO	Emotional/Behavioral/Psychological: Please explain.	:				
□ YES □ NO	Gastrointestinal/Stomach Problems: Please explain:					
□ YES □ NO	Genetic / Rare Disorders: Please explain:					
□ YES □ NO	Headaches: Please explain:					
□ YES □ NO		Both ears	ng loss □ Hearing aid			
\/=0 \\I	□ Tubes □ Cochlear Implant					
□ YES □ NO	Heart Condition:   Activity restrictions:	□ Medications taken	at home:			
□ YES □ NO	Please explain:  Hypertension (High Blood Pressure): Please explain.					
□ YES □ NO	Juvenile Arthritis/Bone-Joint Problems: Please explain.	ain <sup>.</sup>				
□ YES □ NO	Kidney/ Bladder/ Urinary Problems: Please explain:	ann.				
□ YES □ NO	Scoliosis:   No Treatment   Wears Brace	□ Surgery □	Family History			
□ YES □ NO	Seizures/Convulsions: Type of seizure:	<b>.</b>				
	Medications: □ Diastat □ Klonopin □ Versed	□ Medication taken at h	nome   Other			
	Please explain:					
□ YES □ NO	Sickle Cell:   Anemia   Trait					
□ YES □ NO	Shunt:   VP shunt Please explain:					
□ YES □ NO	Spina Bifida:					
□ YES □ NO	Special Diet: Please explain:					
□ YES □ NO	Vision Problems: □ Wears glasses □ Wears cont					
□ YES □ NO	Other Medical Conditions: Please include any medical	cations taken at home o	nıy.			
Required Signatures						
rtoquilou oigilutuloo						

Parent(s) or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_