Community Connections Registration Form 2026-2027

Student's Name _____ DOB _____ Sex _____ Grade *(26-27)*_____

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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 & Address_____ Ph#_____ Relationship_____

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►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. Names will not be included without permission. □ **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 grounds 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.*

Home Language _____

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

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, contact the Site Coordinator <u>before your child starts the</u>** program to complete the documents mandated by the State.

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 the 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

<u>(you MUST list two non-parent contacts)</u>

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_____

Address _____ Home # _____ Work #_____

Emergency Contact #2 _____Relationship_____

Address_____ 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 at a hospital or from a physician at my expense, which may include medical transport. I understand I will be notified first if at all possible.

Signature of Parent/Guardian: _____ Date_____