



2026-27 Franklin County Schools 21st Century Community Learning Center Programs

The program is limited to a specific number of students. Therefore, you will be notified by the site coordinator of when your child may begin the program.

21st CCLC SITE LOCATION (circle one): Phil Campbell East Franklin Tharptown Belgreen Vina Red Bay

Student's Full Name: _____ Birth Date (MM/DD/YYYY): _____

Age _____ Grade (circle one): Kindergarten 1st 2nd 3rd 4th 5th 6th

Race (circle): Native American Asian African American Hispanic or Latino White Other

Mailing Address: _____

Father's Full Name: _____ Phone: _____

Father is authorized to sign student out (circle): Yes No

Father's Employer: _____ Employer's Phone: _____

Mother's Full Name: _____ Phone: _____

Mother's Employer Name: _____ Employer's Phone: _____

Mother is authorized to sign student out (circle): Yes No

Student lives with (circle): Mom Dad Both Parents Grandparents Foster Parents Other Legal

Guardian(if not listed above): _____ Phone: _____

At least one parent email address is required below

Mom/Legal Guardian Email Address: _____

Dad/Legal Guardian Email Address: _____

Please circle the answers below that BEST describe your child:

Bilingual (circle): Yes No

English Language Learner: Yes No

English is my native language(circle): Yes No

Receive Special Education Services (circle): Yes No

In Gifted and Talented Program (circle): Yes No

List any medical concerns/health problems: Allergies, etc.

2026-2027 21st CCLC

Program Contract

Student's Name: _____

I hereby grant permission for my child to participate in the 21st Century Franklin County After School/Summer Program events, activities, and field trips. This may include pre/post, tests, surveys, access to the Internet and enrichment activities. I give permission for my child's work or photos to be used in program implementation and promotion. I grant permission for the 21st Century Staff to have access to my child's school records.

Signature of Parent/Guardian Date

I give permission for the 21st Century After School/Summer program to obtain emergency medical treatment, including emergency transportation, for my child if I cannot be reached immediately. I agree to be responsible for any emergency medical expenses incurred.

Signature of Parent/Guardian Date

PLEASE NOTE THE FOLLOWING:

- Students must not be disruptive or be a threat to themselves or others.
- If you move or change your home/cell phone numbers, please notify your 21st CCLC Site Coordinator ASAP.
- We do not wish to be intrusive, but we must be kept apprised of changes in guardianship, custody, additions, or deletions to the student's daily sign-out release forms as it relates to our care for your child.
- **Please inform anyone who picks up your child to bring a picture ID because we may ask for it at any time. The designated pick-up person must know the child's/children's sign-out PIN.**

Signature of Parent/Guardian

Date

2026-2027 21st CCLC Program Emergency Contacts

Emergency Contacts (other than the parents, in case of accident or illness.) The people listed below have your permission to pick up your child, if you are unable to pick them up. People not listed below will not be allowed to check your child out of the program. We will call the parents at the phone number listed on the first page of this registration packet immediately.

Name Relationship to Student Phone Number

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Special Legal/Custody Restrictions:

21st Century Community Education Learning Center

2026-2027 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 21st CCLC staff will check with your child's classroom teacher(s) to verify homework assignments.
- The 21st CCLC 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 the 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 21st CCLC 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: _____ Date: _____



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HEALTH ASSESSMENT RECORD

School 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	Sex	School
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Address (Street)

Home Telephone Number:	Cell Phone Number:	Additional Phone Number:	Grade	Teacher/Homeroom
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Name of Parent/Guardian (Last, First Middle)	Work Phone Number:
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Transportation

☐ Bus Rider Bus Number: ☐ Car Rider ☐ Special Needs Bus ☐ After School

Part I – Health Information

Place your child receives health care:

Physician's Name: _____

Address: _____

Phone: _____

- ☐ Community Health Center
☐ Health Department
☐ Hospital Clinic
☐ No Regular Place
☐ Private Doctor /HMO

Your child's Insurance Information:

- ☐ ALL KIDS
☐ Medicaid
☐ No Insurance
☐ Other _____
☐ Private Insurance

Place your child receives dental care:

Dentist's Name: _____

Address: _____

Phone: _____

- ☐ Community Health Center
☐ Health Department
☐ Hospital Clinic
☐ No Regular Place
☐ Private Dentist /HMO

Preferred Hospital: _____

Part II – Medical History Medical Equipment /Procedures Required at School

- ☐ Catheter ☐ Gastric Tube ☐ Nebulizer Treatments ☐ Oxygen Supplement ☐ Tracheostomy
☐ Vagal Nerve Stimulator (VNS) ☐ Ventilator ☐ Wheelchair ☐ Walker
☐ Other Please explain:

Medications and Procedures at School require a Prescriber/Parent Authorization Form (one for each medication or procedure) Please see your school nurse.



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HEALTH ASSESSMENT RECORD

School Year: _____ - _____

Name of Student _____

Part III – Medical History

☐ YES ☐ NO	KNOWN HEALTH PROBLEMS If NO , go directly to the bottom of the page and provide parent/guardian signature If YES , and diagnosed by a physician, answer each question below.
☐ YES ☐ NO ☐ YES ☐ NO	Attention Deficit Disorder (ADD) Attention Deficit Hyperactivity Disorder (ADHD) Requires medication ☐ At school ☐ At Home
☐ YES ☐ NO	Allergies: ☐ Food _____ ☐ Insects _____ ☐ Environmental _____ ☐ Medications _____ ☐ Hives/rash ☐ Medications ☐ Breathing difficulty ☐ Epi-pen ☐ Other: _____
☐ YES ☐ NO	Asthma ☐ Uses an inhaler at school ☐ Uses an inhaler at home
☐ YES ☐ NO	Blood/Bleeding Problems: ☐ Hemophilia, ☐ Von Willebrand's, ☐ Other ☐ Requires medication <i>Please explain:</i> _____
☐ YES ☐ NO	Frequent Nose Bleeds: <i>Please explain</i> _____
☐ YES ☐ NO	Cancer/Leukemia: <i>Please explain</i> _____
☐ YES ☐ NO	Cerebral Palsy: <i>Please explain</i> _____
☐ YES ☐ NO	Cystic Fibrosis: <i>Please explain</i> _____
☐ YES ☐ NO	Dental Problems: <i>Please explain:</i> _____
☐ YES ☐ NO	Diabetes ☐ Type 1 Diabetes ☐ Monitors Blood Sugars at school ☐ Requires Insulin at school ☐ Type 2 Diabetes ☐ Managed with diet ☐ Insulin pump ☐ Glucagon order ☐ Oral medication
☐ YES ☐ NO	Emotional/Behavioral/Psychological: <i>Please explain:</i> _____
☐ YES ☐ NO	Gastrointestinal/Stomach Problems: <i>Please explain:</i> _____
☐ YES ☐ NO	Genetic / Rare Disorders: <i>Please explain:</i> _____
☐ YES ☐ NO	Headaches: <i>Please explain:</i> _____
☐ YES ☐ NO	Hearing Problems: ☐ Right Ear ☐ Left Ear ☐ Both ears ☐ Hearing loss ☐ Hearing aid ☐ Tubes ☐ Cochlear Implant
☐ YES ☐ NO	Heart Condition: ☐ Activity restrictions: _____ ☐ Medications taken at home: _____ <i>Please explain:</i> _____
☐ YES ☐ NO	Hypertension (High Blood Pressure): <i>Please explain:</i> _____
☐ YES ☐ NO	Juvenile Arthritis/Bone-Joint Problems: <i>Please explain:</i> _____
☐ YES ☐ NO	Kidney/ Bladder/ Urinary Problems: <i>Please explain:</i> _____
☐ YES ☐ NO	Scoliosis: ☐ No Treatment ☐ Wears Brace ☐ Surgery ☐ Family History
☐ YES ☐ NO	Seizures/Convulsions: Type of seizure: _____ Medications: ☐ Diastat ☐ Klonopin ☐ Versed ☐ Medication taken at home ☐ Other _____ <i>Please explain:</i> _____
☐ YES ☐ NO	Sickle Cell: ☐ Anemia ☐ Trait
☐ YES ☐ NO	Shunt: ☐ VP shunt <i>Please explain:</i> _____
☐ YES ☐ NO	Spina Bifida: _____
☐ YES ☐ NO	Special Diet: <i>Please explain:</i> _____
☐ YES ☐ NO	Vision Problems: ☐ Wears glasses ☐ Wears contacts ☐ Other
☐ YES ☐ NO	Other Medical Conditions: <i>Please include <u>any</u> medications taken at home only.</i> _____

Required Signatures

(Electronic or Written) Parent(s) or Guardian Signature: _____ Date: _____