especiallyneeded

SUPER OWLS AFTERSCHOOL
Registration Form

Email Forms to heather@especiallyneeded.org or mail
SUPER OWLS AFTERSCHOOL PROGRAM
Physical Location: 7605 Virginia Parkway, McKinney TX 75071
Mailing Address: Attn: Heather Astuto 10121 Waterstone Way, McKinney, TX 75070

Select one: _____ I am registering my child who has a special need
_____ I am registering a sibling of my child w/ special needs. ***Special needs profile must be included with this form to complete registration. Form can be found on our website.**

Provide names of all siblings attending the AFTERSCHOOL program: ______________________

PARTICIPANT INFORMATION

Last Name ___________________ First Name ___________________ Nickname__________________

Address ______________________ City _____________ Zip___________ DOB __________________

School ____________________ Grade: _______ Special Needs (if applicable) List all ______________

PROGRAM INFORMATION: 3PM-6:30PM during regular school days for $100 per week. AM care is a possibility so please select AM care if you are interested and we will get back to you asap. We need a minimum number of children registered in order to offer this service. The cost would be an additional $25 per week. A non-refundable deposit of $100 is due immediately to reserve your child's spot. A 2 weeks notice is required to take your child out of the program unless preapproved arrangements are made with the Director. Thank you! **(Check all that apply)**

___ I would like to start my child on (date)___________________________
___ I am interested in PM care for my child
___ I am interested in AM care for my child (waiting on confirmation of services)

Checks are made payable to Especially Needed with OWLS PROGRAM in memo

Parent/Guardian #1	Parent/Guardian #2
First Name:	First Name:
Last Name:	Last Name:
Home Phone:	Home Phone:
Work Phone:	Work Phone:
Email:	Email:
Preferred Method of Contact:	Preferred Method of Contact:

PLEASE PROCEED TO PART 2 OF THIS FORM →

PART 2

HEALTH INFORMATION

The information you provide here will be held in the strictest confidence. It will be kept on file in our health binder or in the possession of the program director.

Child's Doctor's Name: ____________________________________ Phone Number: ______________________

Allergies: ___Yes ____No If yes, please describe the severity of the reaction, requested accommodations and what is done to manage them____

Does your child have any allergic reactions to sunscreen? ____Yes ____No
May we serve your child food and beverages (for snack time): ___ Yes ____ No
Does your child have any food allergies? ____Yes ____No Please list:______________________________

PLEASE SEND A SACK LUNCH TO SCHOOL WITH YOUR CHILD EACH DAY (a refrigerator and microwave is available).

Medications (including Inhalers): ____Yes ____ No

If your child must take medication while attending our program, please note here. All medications must be in their original containers and be appropriately labeled. Please do not give your child's medication to them to bring to facility; medications must be received and held by the program director.

____

Is your child up-to-date on all state-required immunizations? ___Yes ____ No

INSURANCE INFORMATION

Is the participant covered by family medical/hospital insurance? ____ Yes ____ No

Carrier or Plan Name: ______________________ Group #: ______________________

Address ________________________ City ______________________ State ______ Zip Code ________

Name of Insured: __________________________ Relationship to participant: ___________________________
(Print child's name)

WAIVER: (YOUR REGISTRATION FORM WILL NOT BE PROCESSED UNTIL WAIVER HAS BEEN SIGNED.)

INDIVIDUAL CONTRACT

My son/daughter, (full name) ____,
has my permission to participate in the SUPER OWLS AFTERSCHOL
PROGRAM **at Celebration Center – 7605 Virginia Parkway, McKinney, TX 75071.** I understand that reasonable precautions will be taken to safeguard his/her health and safety, and that I will be notified as soon as possible in any emergency. Also, I will not hold liable Especially Needed it's Council members, staff, volunteers, nor any individual lending or giving his/her private property to be used in connection with this event, for any illness or accident. If I am unable to be reached, and the occasion demands, I further authorize any treatment and hospital care advisable under the supervision of licensed medical physician. Such treatment may include x-ray, examination, anesthetic, medical, dental or surgical diagnosis.

One parent/guardian must sign for all minors.

I have read this entire Informed Consent Agreement. I fully understand it and I agree to be legally bound by it.

________________________________ ______________________

Signature of Parent/Guardian of Minor Date

____

Participants name

FOR OFFICIAL USE ONLY

PROOF OF AGE: ☐ Yes ☐ No **Type of proof:** ☐ ID Card ☐ Birth Certificate ☐ Other: ______ **Staff Initials:** _____
PAID CAMP FEE: ☐ Yes ☐ No **Type of payment:** ☐ Cash ☐ Check **Staff Initials:** _____