|  |  |  |
| --- | --- | --- |
| For Office Use Only: |  | |
| Date Received Appl. |  | Moriah |
| Start Date: |  |  |
| End Date: |  |  |

Adirondack Community Action Program, Inc.

7572 Court Street, Suite 2

P.O. Box 848

Elizabethtown, NY 12932

Phone: (518)-873 -3207 ext.235

Fax: (518)-873-4879

Email: btaylor@acapinc.org

**AFTERSCHOOL PROGRAM REGISTRATION 2025 - 2026**

***Child to be enrolled in program*:**

­

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

First Name M.I. Last Name Date of Birth Age

|  |  |  |
| --- | --- | --- |
|  |  | Gender: (check one) Female Male |

Teacher Grade (2025 - 2026)

|  |  |
| --- | --- |
|  |  |

***First Parent / Guardian Information***:

Name of First Parent/Guardian Relationship to child

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |

Mailing Address City State Zip Code

|  |  |  |
| --- | --- | --- |
|  |  |  |

Primary Home Phone Number Cell Phone Email Address

|  |  |
| --- | --- |
|  |  |

Employment Work Phone Number

|  |  |
| --- | --- |
|  |  |

***Second Parent / Guardian Information***:

Name of Second Parent/Guardian Relationship to child

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |

Mailing Address City State Zip Code

|  |  |  |
| --- | --- | --- |
|  |  |  |

Primary Home Phone Number Cell Phone Email Address

|  |  |
| --- | --- |
|  |  |

Employment Work Phone Number

**EMERGENCY CONTACTS: (Other than Parent/Guardians)**

In case the Parent/Guardian cannot be reached the following people have permission to pick up my child in an event of an illness or emergency.

***First Emergency Contact Information***:

Name of Emergency Contact Person

|  |  |  |
| --- | --- | --- |
|  |  |  |

Primary Phone Secondary Phone Cell Phone

**AFTERSCHOOL PROGRAM REGISTRATION**

***Second Emergency Contact Information***:

Name of Emergency Contact Person

|  |  |  |
| --- | --- | --- |
|  |  |  |

Primary Phone Secondary Phone Cell Phone

***Emergency/Snow Closings:*** In the event that school is closed early or there are no after school activities, you will be notified by the school.

***Additional Authorized people who can pick up my child:***

|  |  |
| --- | --- |
| Name of Authorized Person | Contact Number |
| 1.) |  |
| 2.) |  |
| 3.) |  |
| 4.) |  |
| 5.) |  |

***Medical Information:***

1.) Does your child have any food allergies? Yes No

If Yes, Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.) Does your child have any other allergies? Yes No

If Yes, Please List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.) Is your child presently taking medications? Yes No

If Yes, Please List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.) Are there any physical conditions that the Afterschool staff should be aware of concerning your child?

If Yes, Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***I agree that in case of accident or injury, emergency medical care may be given in the event that I, or the person(s) designated cannot be reached.***  YesNo

***GENERAL INFORMATION:***

Does your child receive Special Education Services in school? Yes No

If Yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AFTERSCHOOL PROGRAM REGISTRATION**

Does your child have an I.E.P.? Yes No

Does your family participate in the Free/Reduced lunch program? Yes No

***I give my permission for ACAP to obtain a copy of my income eligibility form for Free/Reduced lunch from the school district.*** YesNo

Does your family receive TANF funding? Yes No

Are you eligible for Subsidy? Yes No

Why would you like your child to participate in the ACAP Afterschool program? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your current child care arrangements? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide us with special information to assist the staff in caring for your child (diet, habits, behavior, personality, likes and dislikes, nicknames, etc). \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***AGREEMENTS:*** *Please initial each line as marked in acknowledgement.*

\_\_\_\_\_\_\_\_I have been advised of the policies and procedures regarding transportation and the services provided by A.C.A.P. (Adirondack Community Action Programs, Inc.) and the regulations under which it operates.

\_\_\_\_\_\_\_\_Local media (press, TV stations, and newsletter publications) run news stories about ACAP and its programs. I give my permission for my child to be photographed or filmed in conjunction with news coverage of the program.

\_\_\_\_\_\_\_\_I give permission to the after-school program staff to speak to my child’s teacher in order to help him/her to be successful in school.

**Childs Ethnicity**

**\_\_\_\_\_ American Indian**

**\_\_\_\_\_ Asian**

**\_\_\_\_\_ Black/African American**

**\_\_\_\_\_ Hispanic/Latino**

**\_\_\_\_\_ Native Hawaiian or Pacific Islander**

**\_\_\_\_\_ White**

***Signature Page:***

|  |  |
| --- | --- |
| How did you learn about Adirondack Community Action Program, Inc.? |  |

|  |  |
| --- | --- |
|  |  |

Parent / Guardian Signature Date

|  |  |
| --- | --- |
|  |  |

Authorized After School Staff Date