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



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 (2024 - 2025)

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

***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

|  |  |  |
| --- | --- | --- |
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Primary Home Phone Number Cell Phone Email Address

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

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

***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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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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). \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***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. ACAP has permission to share my application with the Bouquet Valley School District.

\_\_\_\_\_\_\_\_I give permission to the afterschool 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**

***My Child may choose to attend Oasis Afterschool activities that interest them throughout the 2024-2025 School Year***

***Please check below***

***Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***NO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Signature Page:***

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

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

Parent / Guardian Signature Date

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

Authorized After School Staff Date