2023/2024 PROJECT BOOST ENROLLMENT FORM

VINTON COUNTY LOCAL SCHOOL DISTRICT'S AFTER SCHOOL PROGRAM

PLEASE COMPLETE THE EMERGENCY MEDICAL FORM ON THE BACK. PLEASE SIGN THE PROJECT BOOST DISCIPLINE AND BEHAVIOR MANAGEMENT POLICY AND RETURN WITH THE ENROLLMENT FORM.

Forms must be on file before your child can stay at Project Boost.

School ____________________________________

Student's Name ____________________________________ Male ______ Female ______

Homeroom Teacher ____________________________________ Grade ______________________________

Parents or Guardian ____________________________________ Phone Number ________________________

Home Address ____________________________________ City/St/Zip ____________________________

Email Address ____________________________________ Cell Phone ____________________________

My child ____ CAN _____CANNOT be photographed for Project Boost press releases or newspaper articles.

My child ____ CAN _____CANNOT participate in activities coordinated by outside agencies (Girl Scouts, Extension, etc.)

My child ____ DOES _____DOES NOT have an IEP ***Total in Household*** *____ ADULTS (over 18) ____CHILDREN* ***At the end of afterschool programming, my child will: (choose all that apply)***

_____ **WALK** *(If your child walks home from Project Boost, they will be dismissed at the end of the program unless previous arrangements for early dismissal have been made in writing.)*

_____ **CAR RIDE** *(All students must be signed out in person. Drivers will need to enter the building.)*

The following people HAVE PERMISSION to pick up my child from Project Boost:

Name ____________________________________ Phone ____________________________________

Name ____________________________________ Phone ____________________________________

Name ____________________________________ Phone ____________________________________

Please list anyone that is NOT allowed to pick up your child.

Name ____________________________________ Name ____________________________________

Name ____________________________________ Name ____________________________________

By signing this side of the enrollment form, you agree that this information provided is accurate. You must provide Project Boost with any changes in a timely manner and in writing.

____ ______________________________

Parent/Guardian Signature ***Date***

EMERGENCY MEDICAL AUTHORIZATION 5341 F1

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Student's Name ______________________________ Birthdate________________Grade __________

Address ______________________________ Teacher/Homeroom ____________________ City/State/Zip

______________________________ Date of Last Tetanus ____________________ SS# of Student

______________________________ Bus Number (if applicable) __________________ Student Resides

With (*circle all that apply*) **Mother Father Grandparents Guardian Other** ___________

List only the names (first and last) of those who have authority to make decisions in an emergency situation involving this student. Then, indicate on the line to the left the order in which you desire contact attempts to be made based on availability (i.e. 1st, 2nd, etc.)

_____ Mother ____________________________ Home #________________ Work #________________

_____ Father ____________________________ Home #________________ Work #________________

_____ Grandparent ________________________ Home #________________ Work #________________

_____ Guardian __________________________ Home #________________ Work #________________

_____ Relative or Alternate (i.e. child care provider, aunt, etc.) Relationship to Child ____________________

Name____________________________Home #________________ Work #________________

Complete ONLY ONE of the following: 1] Consent for Treatment OR 2] Refusal to Consent

1] CONSENT FOR TREATMENT

I hereby give consent for the following medical care providers and local hospital to be called:

Preferred Physician__________________________

Office #__________________________

Preferred Dentist__________________________

Office #__________________________

School Nurse ____YES ____NO

Office # **(740) 596-5218**

Preferred Hospital __________________________

ER #__________________________

2] REFUSAL TO CONSENT

I **DO NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

____

____

____

Parent/Guardian Signature____________________

Address______________________________

Date______________________________

AND in the event *reasonable* attempts to contact me have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by above-named doctor, **OR** (2) in the event the designated preferred practitioner is not available, by another licensed physician or dentist; **AND** (3) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

MEDICAL HISTORY: Facts concerning the child's medical history including allergies, current medications, and any physical impairment of which a physician and/or school personnel should be alerted include:

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______________________________________ ______________________

Parent/Guardian Signature ***Date***