

# Application For Summer All-Day Programs 2019



Choose from the program options below:

Enrollment Date: (First date student is to attend program) \_\_\_\_\_

**Super Summer Club (completed k-3<sup>rd</sup> grade)**

**Camp Extreme (completed 4<sup>th</sup>-8<sup>th</sup> grade)**

Check weeks needed:

May 28–May 31

June 10-14

June 24-28

July 8-12

July 22-26

June 3-7

June 17-21

July 1-5 (no program July 4)

July 15-19

July 29-Aug. 2

**Student's T-shirt size:** Youth  S  M  L Adult  S  M  L  XL

**Student's Information:**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Grade 2018/2019 \_\_\_\_\_ School attended 2018/2019 \_\_\_\_\_

Student's address: \_\_\_\_\_

Gender:

Male

Female

**Parent or Legal Guardian Information:** (Primary individual responsible for student's account):  Yes  No

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Last 4 digits of SS#: \_\_\_\_\_

Address: (if different from student's address above) \_\_\_\_\_

Relationship with student:

Parent

Foster Parent

Custodial Parent

Legal Guardian

Home Phone: \_\_\_\_\_ / \_\_\_\_\_ Cell Phone: \_\_\_\_\_ / \_\_\_\_\_ Cell Service Provider: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ / \_\_\_\_\_

Daytime e-mail: \_\_\_\_\_ Work Hours: \_\_\_\_\_

Preferred Method of Contact:  Phone  Email  Text message (must list cell service provider)

**Additional Parent/Guardian Information:** (Secondary individual responsible for student's account):  Yes  No

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Last 4 digits of SS#: \_\_\_\_\_

Address: (if different from other parent's/guardian's address above) \_\_\_\_\_

Relationship with student:

Parent

Foster Parent

Custodial Parent

Legal Guardian

Home Phone: \_\_\_\_\_ / \_\_\_\_\_ Cell Phone: \_\_\_\_\_ / \_\_\_\_\_ Work Phone: \_\_\_\_\_ / \_\_\_\_\_

Employer: \_\_\_\_\_ Work Hours: \_\_\_\_\_

Daytime e-mail: \_\_\_\_\_

**NOTICE:** Failure to list or disclose complete information will result in student's suspension from the program until complete information is provided to the office.

**Emergency Information:** Other than parents/guardians, in case of emergency, please notify: (this person will also be allowed to pick-up your student)

Name	Cell Phone Number	Other Phone Number	Relationship with student
_____	_____	_____	_____

Please list the names of people **other than parents and the emergency contact person** listed above who are permitted to pick up your student.

Name	Cell Phone Number	Other Phone Number	Relationship with student
_____	_____	_____	_____

Name	Cell Phone Number	Other Phone Number	Relationship with student
_____	_____	_____	_____

Name	Cell Phone Number	Other Phone Number	Relationship with student
_____	_____	_____	_____

Please list any person who is **NOT** allowed to pick up your student. \_\_\_\_\_

Court documents: (must provide copies of any official court documents)     Custody Orders     Restraining Orders

**Student's Medical and Developmental Information:**

Physician's Name \_\_\_\_\_ Telephone \_\_\_\_\_/\_\_\_\_\_ Hospital Preference \_\_\_\_\_

I give permission for Community Education to administer medication per the instructions listed below. \_\_\_\_\_  
\*Parent/Guardian Signature\*

List any **medications** your student will receive **during program hours**. Please include the dosage of each medication and the time that the medicine is to be given. \_\_\_\_\_

List any **medications** your student takes **outside of program hours**. Please include the dosage of each medication and the time that the medicine is given. \_\_\_\_\_

In planning our programs to meet your student's needs, we must have pertinent information, including any medical, behavioral or cognitive assessments. We also need to be aware of any services provided to your student during the day.

Please check if student has any of the following: (check all that apply)

- Diabetes     Frequent colds     Earaches     Developmental delays     Stomach Aches     Epilepsy
- High Fevers     Toileting assistance     Hearing Aid     Special Needs     Physical disabilities
- Emotional or behavior disorder     ADHD     Autism     Glasses     IEP or 504 Plan\*
- Other (specify) \_\_\_\_\_
- My student has none of the above symptoms or conditions.

**\*IEP or 504 Plan:** If so, you must provide a copy of the current plan before your student can attend the program, so we can provide consistent direction, etc. The current plan is required before the application can be processed. Upon receipt of the current plan, we will evaluate existing staff to determine whether additional training is necessary or additional staff needs to be hired. We will facilitate such measures as quickly as possible. You will be notified when appropriate staffing is in place so that the student can begin attending the program.

List allergies and allergy symptoms:

- Asthma     Hay Fever     Hives     Food (please specify) \_\_\_\_\_
- Runny Nose     Watery Eyes     Other (please specify) \_\_\_\_\_
- My student has none of the above symptoms or conditions.

**NOTE:** You must provide Community Education with a doctor's note verifying the condition and any relevant medication for any medical condition requiring accommodations or treatment (alternate snack due to food allergies, EpiPen, other medication, etc.) before your student may start in the program.

Print Student's Full Name: \_\_\_\_\_

Print Student's Birthdate: \_\_\_\_\_

All the information on this application is completed accurately. I know that complete and accurate information is necessary to best serve my student. I understand that it is my responsibility to notify Community Education of any changes in employment, residence, phone numbers, and any emergency information that may change.

\_\_\_\_\_  
Initials\*

1. I hereby authorize Community Education to seek medical treatment for my student in the event of an emergency, including transportation by ambulance to the nearest hospital. **I understand that I am solely responsible for any medical expenses including ambulance transportation**, which my student may incur for any injuries, including those resulting from on-site injuries or off-site on an approved field trip. I hereby release Community Education from any and all claims or causes of action for any injuries sustained by my student at the program.

\_\_\_\_\_  
Initials\*

2. I give permission for my student to participate in Community Education field trips, whether by walking a short distance or being transported from program on field trips, outings or other center-sponsored activities. I hereby release Community Education from any and all claims or causes of action for any injuries sustained by my student in being transported to or from program. A separate, signed permission slip is needed for bus trips.

\_\_\_\_\_  
Initials\*

3. I understand that a copy of Community Education's Parent Handbook, site-specific disaster plans, and camp information sheets are readily available online at [www.commed.us](http://www.commed.us), and I will review and abide by the provisions therein. I also understand that hard-copies of each are available by request at the Community Education office.

\_\_\_\_\_  
Initials\*

4. *Optional* - I give my student permission to watch only G rated movies during summer camp at Super Summer Club or Camp Extreme. This includes the movies shown at the Great Escape Theater.

\_\_\_\_\_  
Initials\*

5. *Optional* - I give my student permission to watch both G and PG rated movies during summer camp at Super Summer Club or Camp Extreme. This includes the movies shown at the Great Escape Theater.

\_\_\_\_\_  
Initials\*

6. *Optional*—Occasionally a newspaper or television station visits to promote student's activities. Community Education has a website, Facebook and Twitter pages where we occasionally post photos of students engaged in educational programs. I agree to allow my student to participate in these activities.

\_\_\_\_\_  
Initials\*

**NOTE:** Participation in Community Education programming is voluntary. Only students whose parents/guardians have agreed to sections 1-4 and the consent to Release Records form will be accepted into the programs. Section 5-7 are optional.

Check applicable box:

- I am this student's parent.
- I am this student's legal guardian.
- I am this student's foster parent.

\_\_\_\_\_  
Print Your Name

\_\_\_\_\_  
Complete Signature\*

\_\_\_\_\_  
Date



# Bowling Green – Warren County Community Education

## Consent to Release Education Records

RE: \_\_\_\_\_  
Print Student's Full Name

\_\_\_\_\_  
Student's Date of Birth

Community Education works with the school districts to provide consistent direction for students.

I hereby authorize Bowling Green – Warren County Community Education and any school district or educational agency in which my above-named student is or has been enrolled to release and/or provide to each other copies of all my student's records in each entity's possession. This authorization includes my consent to release to the school district in which my student is or will be enrolled and to Bowling Green – Warren County Community Education any and all of my student's education records which would otherwise be protected from disclosure under the Family Educational Rights and Privacy Act, 20 U.S.C. §1232, and the Kentucky Family Education Rights and Privacy Act, KRS 160.700-160.990. I acknowledge my signature (electronically or otherwise) in this agreement constitutes my legal, binding signature. By signing my full name below, I confirm that I am the appropriate legal party to sign this agreement, and I am the person who is signing below and authorizing release.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Parent or Guardian

Check applicable box for person signing above:

Parent

Guardian

Note: Only students whose parents/guardians have agreed to this consent will be accepted into the programs.