Adirondack Community Action Program, Inc.
7572 Court Street, Suite 2
P.O. Box 848
Elizabethtown. NY 12932
(518)873-3207 ext.235
Fax #(518) 873-6845

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

AFTERSCHOOL PROGRAM REGISTRATION 2023 - 2024

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

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

Teacher	Grade (2023 - 2024)	Gender: (check one) ☐ Female ☐ Male

***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

Adirondack Community Action Programs, Inc.

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. ☐ Yes ☐ No

GENERAL INFORMATION:

Does your child receive Special Education Services in school? ☐ Yes ☐ No
If Yes, please explain: ____
____

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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. ☐ Yes ☐ No

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). ____
____
____

<u>AGREEMENTS:</u>
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**.**

If your child will be attending ACAP Afterschool Monday-Friday 3:00-6:00pm and half days. Please check the line below

_________ I agree to pay $150 for the first child/month, $75 for the second child, and $37.50 for the third child, or I will apply for DSS Subsidy.

You can contact DSS for subsidy information (518)873-3431 Family who are seeking DSS should contact ACAP at (518)873-3207 ext.235.**Parents are responsible for payment until approval of subsidy.** You can pay be check or are able to make credit card payments by calling office at 518-872-3207 ext243. We will be introducing a new payment program that will you will have your own account and will be able to pay and have the best payment option that suits your needs. Until then you will still use the current billing and payment method. **You are still also be required to make first month's payment due when you sign up your child/children.** More information to come.

If your child is ONLY attending Oasis weekly or on ½ Days there is no cost

Oasis Afterschool Clubs 2023-2024 Please Select ANY from The Following If you Didn't check the box above

______ My Child will be picked from the Oasis Club they are attending (Monday-Thursday) and ½ days at the designated spot

______My Child will be going to ACAP Afterschool when their club ends (Monday-Thursday) and will be picked up by 5:15

______ If you want your child to attend half days the cost will be 100.00 for the school year and needs to be paid at the time that you sign your up child.

Child's 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