Adirondack Community Action Program, Inc.
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For Office Use Only:		
Date Received Appl.		☐
Start Date:		☐ BVCS
End Date:		☐
		☐ Oasis

O.A.S.I.S. Afterschool

AFTERSCHOOL PROGRAM REGISTRATION 2024 - 2025

***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

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

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). _____
_____
_____

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.

Child's 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