

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

For Office Use Only:	
Date Received Appl.	<input type="checkbox"/>
Start Date:	<input type="checkbox"/> BVCS
End Date:	<input type="checkbox"/>
	<input type="checkbox"/> Oasis



AFTERSCHOOL PROGRAM REGISTRATION 2024 - 2025

Child to be enrolled in program:

First Name	M.I.	Last Name	Date of Birth	Age
			Gender: (check one) <input type="checkbox"/> Female <input type="checkbox"/> 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:

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Name of Emergency Contact Person

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Primary Phone

Secondary Phone

Cell Phone

Second Emergency Contact Information:

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Name of Emergency Contact Person

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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?
If Yes, please explain: _____

Yes No

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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.?	
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Parent / Guardian Signature	Date
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Authorized After School Staff	Date
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**Universal Permission Slip
Boquet Valley Central School
OASIS Afterschool Program
2024-2025**

Please review the information below. Initial next to the statement if you permit your child to attend the outings. If you do not, then please write "no" next to the statement. Sign the form at the bottom of the page. Students should return this form and registration packet to the main office of their respective school location. Additional forms are available upon request. Please email (mmiller@boquetvalleycsd.org) or call 518-873-6371 ext 2507 to speak with Marcail Miller, OASIS Coordinator. One form is required per student.

Universal Field Trip:

This permits your child to attend outings within one hour's drive from Boquet Valley Central School District campuses. Examples include but are not limited to trips to Plattsburgh, Lake Placid, Ticonderoga, etc. This also permits your child to participate in afterschool walks/running clubs, hiking trips, mountain biking trips, etc. All trips will be supervised. Any trip beyond an hour's drive from either campus location will require another permission slip form to be signed for all enrolled OASIS students.

_____ I give my child permission to attend OASIS Afterschool functions this year.

Student Name (Please print)

Teacher (Lake View & 6th grade only)

Parent/Guardian Name (Please print)

Parent/Guardian Signature

Date