MHACG
MHA of Columbia-Greene

Hudson After School Program
Student Registration Form

STUDENT FAMILY INFORMATION

Date:

School:
○ M.C. Smith Elementary ○ Hudson Jr. High

Session: *(to be completed by program)*

Last Name:

First Name:

Date of Birth:

Gender:

Grade:

Teacher:

Parent/Guardian Last Name:

Parent/Guardian First Name:

Relationship to Student:
○ Parent ○ Caretaker
○ Guardian ○ Relative
○ Other:

Street Address:

City:

State:

Zip:

Primary Phone:

Secondary Phone:

Email Address:

Student Racial/Ethnic Group:
○ White ○ Black or African American ○ Hispanic or Latino ○ Two or more races
○ Asian ○ American Indian/Alaska Native ○ Native Hawaiian/Pacific Islander ○ Other *(specify):*

EMERGENCY CONTACT INFORMATION

Please provide at least two (2) emergency contacts, in addition to the parent or guardian listed above.

Primary Contact:

Primary Phone:

Secondary Phone: *(optional)*

Authorized to Pick Up:
○ Yes ○ No

Secondary Contact:

Primary Phone:

Secondary Phone: *(optional)*

Authorized to Pick Up:
○ Yes ○ No

Additional Contact: *(optional)*

Primary Phone:

Secondary Phone: *(optional)*

Authorized to Pick Up:
○ Yes ○ No

RELEASE OF STUDENT AT DISMISSAL

Please list all adults authorized to pick up your child. Program staff will **only** release your child to individuals on this list. Photo identification may be required to ensure safety.

I give my child permission to sign out at dismissal. **JR High Only* ◯ Yes ◯ No

My child has permission to take the bus. ◯ Yes ◯ No

If your child will take the bus, they will be dropped off at central locations. Please check the attached bus routes and indicate where your child will be dropped off:

My child may be picked up by me or one of the following individuals:

Name:	Primary Phone:	Relationship:
Name:	Primary Phone:	Relationship:
Name:	Primary Phone:	Relationship:

HEALTH AND SAFETY INFORMATION

Per Reg. 414.15(C)(6) we are required to maintain records for consent to medical treatment and health care provider. MHA of Columbia Greene is a health care provider that complies with all HIPAA confidentiality and privacy laws. All information is confidential and used solely by program staff to ensure the safety of students. To review our Notice of Privacy Practices, visit mhacg.org/privacy.

I grant permission for program staff to seek emergency medical treatment, if necessary: ◯ Yes ◯ No

Are immunization records filed at the school? ◯ Yes ◯ No

Necessary medical information & accommodations:

Name of Child's Physician: Primary Phone:

List Allergies: Need/Use an EpiPen? ◯ Yes ◯ No

Please advise if your child needs any accommodations to participate in the program, for example medical, physical, or dietary restrictions:

CLUB INTEREST

Please enter your child's first and second preferred choice for club group activities during the week. Club availability changes throughout the year. We will use the preferences below to connect with meaningful activities for the child whenever possible. Preferences do not guarantee placement.

1st Choice

	Monday	Tuesday	Wednesday	Thursday	Friday
3:15 - 4:10					*Open Recreation*
4:15 - 5:15					*Open Recreation*
5:15 - 6:00	*Open Recreation Available Daily*				

2nd Choice

	Monday	Tuesday	Wednesday	Thursday	Friday
3:15 - 4:10					*Open Recreation*
4:15 - 5:15					*Open Recreation*
5:15 - 6:00	*Open Recreation Available Daily*				

OFFICE USE ONLY

3:15 - 4:10

4:15 - 5:15

Additional Information:

AGREEMENTS

I understand that the following agreements and consents are not pre-conditions for approval to participate in the Learning and Enrichment After School Program Supports (LEAPS) | 21st CCLC. ◯ Yes ◯ No

I consent for my child to participate in interviews, the use of quotes, and the taking of photographs, movies, or videotapes by the MHACG After School Program staff. I also grant MHACG the right to edit, use, and reuse said products for non-profit purposes including use in print, on the internet, and all other forms of media. I also hereby release MHACG and its agents and employees from all claims, demands, and liabilities whatsoever in connection with the above. ◯ Yes ◯ No

I consent for my child to take part in field trips, away from the program site, under supervision. ◯ Yes ◯ No

I understand the program may need additional permissions for situations such as transportation, medication, release of information and field trips. ◯ Yes ◯ No

I provided information on my child's special needs to the program to assist in the safety of my child. ◯ Yes ◯ No

I agree to review and update this information whenever a change occurs and at least once every year. ◯ Yes ◯ No

I understand that if at any time I change my mind about my child's participation (in any or all aspects), I will contact the site coordinator. ◯ Yes ◯ No

By signing below, I understand that my child's academic, behavioral, attendance, and engagement information may be shared with the New York State Education Department and its lawful contractors, to measure and evaluate the quality and implementation of the local 21st Century Community Learning Center (21st CCLC) program as well as the effectiveness New York State's program in supporting student growth, as required by Title IV, Part B of the Every Student Succeeds Act (ESSA) [see generally sections 4205 (b) and 4203 (14)].

By signing below, I grant my child permission to participate in the Learning and Enrichment After School Program Supports (LEAPS) | 21st CCLC program and certify that all information contained in this registration form is true and correct to the best of my knowledge.

Signature of Parent/Guardian	*Printed Name*	*Date*