

PROGRAM ENROLLMENT FORM

School Year 2023-2024

(Print all information)

STUDENT INFORMATION

Last Name		First Name		Middle Name	Student Age
Ethnic Designation: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino	Race (choose one or more): <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black/African American			Date of Birth (mm/dd/yyyy) / /	Student's Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
	Country of Birth (if other than US):			Phone number: ()	
Street Address		Apt. No.		Student's School Information	
City		State	ZIP	Current School: City, State, Zip:	
Grade Level next school year (18-19)				Graduating This Year <input type="checkbox"/> Yes <input type="checkbox"/> No	
K 1 2 3 4 5 6				Are you interested in UVSO AfterSchool Program <input type="checkbox"/> Yes <input type="checkbox"/> No	
7 8 9 10 11 12 Adult				Allergies (if "yes", please complete form) <input type="checkbox"/> Yes <input type="checkbox"/> No	
				Dietary restrictions (if "yes", please complete form) <input type="checkbox"/> Yes <input type="checkbox"/> No	
				Required medications (if "yes", please complete form) <input type="checkbox"/> Yes <input type="checkbox"/> No	

PARENT/GUARDIAN INFORMATION

Parent/Guardian		Relationship		Other Parent/Guardian/Contact		Relationship	
Street Address				Street Address			
City		State	Zip	City		State	Zip
Email Address		<input type="checkbox"/> Email opt-in <input type="checkbox"/> Text message opt-in		Email Address		<input type="checkbox"/> Email opt-in <input type="checkbox"/> Text message opt-in	
Home Phone	Cell Phone	Work Phone		Home Phone	Cell Phone	Work Phone	

SIBLING INFORMATION

	Sibling 1	Sibling 2	Sibling 3	Sibling 4
Name				
Student Age				
School				
Date of birth				

EMERGENCY CONTACT INFORMATION (OTHER THAN PARENT/GUARDIAN)

Name		Relationship		Name		Relationship	
Street Address				Street Address			
City		State	Zip	City		State	Zip
Home Phone	Cell Phone	Work Phone		Home Phone	Cell Phone	Work Phone	

Child's Favorite Snack (CHECK ALL THAT APPLY)

Chips <input type="checkbox"/>	Gold Fish <input type="checkbox"/>	Pizza <input type="checkbox"/>	Pretzals <input type="checkbox"/>	Fruits Snacks <input type="checkbox"/>	Teddy Ghrams <input type="checkbox"/>	String Cheese <input type="checkbox"/>	Ice pops <input type="checkbox"/>
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UVSO agrees that the data/information provided in the Student Enrollment Form remain confidential and shall only be used for legitimate UVSO business. I completed this form and I certify that the information above is accurate. I understand that providing false information for purposes of defrauding the government is punishable by law. By signing below, I acknowledge my agreement with any consents or opt-ins provided in this form. Form should not be signed prior to April 1.

Signature of Enrolling Parent/Guardian _____

Date _____

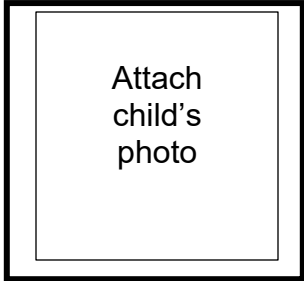
Allergy and Anaphylaxis Emergency Plan



Child's name: _____ Date of plan: _____

Date of birth: ___/___/___ Age _____ Weight: _____ kg

Child has allergy to _____



- Child has asthma. Yes No (If yes, higher chance severe reaction)
 Child has had anaphylaxis. Yes No
 Child may carry medicine. Yes No
 Child may give him/herself medicine. Yes No (If child refuses/is unable to self-treat, an adult must give medicine)

IMPORTANT REMINDER

Anaphylaxis is a potentially life-threatening, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis What to look for



If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine.**

- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of "doom," confusion, altered consciousness, or agitation

SPECIAL SITUATION: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): _____. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine.**

Give epinephrine! What to do

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911.
 - Ask for ambulance with epinephrine.
 - Tell rescue squad when epinephrine was given.
3. Stay with child and:
 - Call parents and child's doctor.
 - Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes.
 - Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
 - Antihistamine
 - Inhaler/bronchodilator

For Mild Allergic Reaction What to look for



If child has had any mild symptoms, **monitor child.**

Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Monitor child What to do

Stay with child and:

- Watch child closely.
- Give antihistamine (if prescribed).
- Call parents and child's doctor.
- If more than 1 symptom or symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

Medicines/Doses

Epinephrine, intramuscular (list type): _____ Dose: 0.10 mg (7.5 kg to less than 13 kg)*
 0.15 mg (13 kg to less than 25 kg)
 0.30 mg (25 kg or more)

Antihistamine, by mouth (type and dose): _____ (*Use 0.15 mg, if 0.10 mg is not available)

Other (for example, inhaler/bronchodilator if child has asthma): _____

Parent/Guardian Authorization Signature

Date

Physician/HCP Authorization Signature

Date

Child's name: _____ Date of plan: _____

Additional Instructions:

Contacts

Call 911 / Rescue squad: _____

Doctor: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Other Emergency Contacts

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

DIETARY RESTRICTION FORM

CHILD'S NAME: _____ Date of Birth: _____

Doctors Names: _____ Dr.'s phone: _____

What foods are not allowed:

What Happens, if your child does ingest restricted foods:

What needs to be done, if your child ingests the restricted foods:

Is there any medication needed, in case your child is exposed, and what is the procedure:

Do you have any recommendations or suggestions:

What food is safe, or alternatives to certain foods:

Parent Signature

Date



AFTER SCHOOL PROGRAMS

Parent Consent and Photo Release Form

Please sign and return this consent form to your child's teacher. There are two different items that require your signature – photo consent and directory information. For each item, please sign consent or no consent. Please return this form to your child's teacher. Thank you for your assistance.

At various times Unified Vailsburg Service Organization (UVSO), partners/vendors of UVSO and a variety of media outlets request permission to film, video tape and photograph our schools. They subsequently publish, broadcast or use these materials, which often include images and depictions of students, as well as student work products.

If you consent and grant permission for your child's likeness or work products to be used/featured by your school, UVSO/its partners or electronic or social media, please sign in the appropriate space below.

1) Photo Consent: I do consent and allow my child to be filmed, videotaped and/or photographed for use by my school, UVSO/its partners and the media. I also allow my child's work product to be featured by UVSO (this will include the school yearbook and social media).

Child's Name	Parent's Signature	Date

No Photo Consent: I do **NOT** consent nor allow my child to be filmed, videotaped and/or photographed for use by my school, UVSO/its partners and the media (this will include the school yearbook and social media).

Child's Name	Parent's Signature	Date

2) Directory Information Consent:

I do consent and allow the district to release directory information on my child. Directory information includes the student's name, place and date of birth, major course of study, participation in sports and other official school activities, height and weight if an athletic team member, date of graduation, dates of attendance (date of enrollment through date of withdrawal or graduation), degrees and awards.

Child's Name	Parent's Signature	Date

No Directory Information Consent: I do **NOT** consent nor allow the district to release directory information on my child.

Child's Name	Parent's Signature	Date



BLANKET PERMISSION FOR WALKING TRIPS

Center Name: _____

Child's Name: _____

I hereby give permission for my child to participate in walking trips in the neighborhood around the center. I understand that the walking route is within the center's neighborhood, includes no known safety hazards, and that the walks will not involve entrance into any facility other than the following:

Signature of Parent/Guardian

Date