Bridge 2 Success Enrollment Form

Out-of-School Time and Summer Camp Programs

3409 Baseline Road, Suite B
Little Rock, AR 72209
(501) 565-0100

Out-of-School Time and Summer Camp Programs

Last Name: _____ **First Name:** _____ **MI:** _____

Email address: _____

Enrollment Date _____ **PROGRAM (*circle one*):** ☐ **Out-of-School** **or** ☐ **Summer Camp**

Participant Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

IDENTIFICATION SECTION

Address: _____ **City:** _____ **Zip:** _____

Sex: ☐ **Male** ☐ **Female** **RACE:** ☐ **Black** ☐ **White** ☐ **Hispanic** ☐ **Other**

Primary Language Spoken at Home: _____ **Secondary Language Spoken at Home** _____

Birthday: ____/____/____ **Age:** _____ **Grade:** _____ **Phone:** _____

School: _____ **Grade:** _____ **School ID/Lunch Number:** _____ **Free/Reduced Lunch (circle one):** **Yes** **No**

Does this student require special modifications/allergies (i.e., special needs, dyslexia, ADHD, etc.)?

Check a box and list condition(s): ☐ Yes ☐ No List condition(s) _____

City of Little Rock—Prevention and Intervention Programs

This program receives funding from the City of Little Rock's Prevention and Intervention Funds *(This program is free of charge)*

Bridge 2 Success Parent Permission Form

Photo/Social Media/Video Release Agreement:

- ☐ I consent to having my child photographed/videoed.
- ☐ I do *not* consent to having my child photographed/videoed.

Transportation:

- ☐ I (or someone I designate) will pick up my child up from the out-of-school time program.

Name of Person: _____

Contact Information: _____

- ☐ My child will take the bus (or other provided transportation home) after the program ends.
- ☐ My child will walk alone from the program.
- ☐ Other: _____

Authorization to Consent to Medical Treatment:

In the event that I cannot be contacted to give my consent, I hereby authorize the program coordinator and/or employees consent to:

- ☐ The administration of any treatment deemed available by a licensed physician or dentist, and
- ☐ The transfer of my child to any hospital reasonably accessible.
- ☐ I agree to pay all applicable fees/costs with medical treatment.

Physician Name: _____ **Phone**: _____

Surveys:

This program may allow surveys occasionally in order to improve procedures. (***Note***: any survey that is part of a research study or for any purpose other than program improvement will have a separate permission process.)

- ☐ I give my consent
- ☐ I do not give my consent

City of Little Rock—Prevention and Intervention Programs

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Bridge 2 Success Parent Agreement

Agreement I: I agree to support the Bridge 2 Success (B2S) *Out of School Time Program* (OST) and *Summer Program* (SC) rules and procedures to ensure the health and safety of my child/children and other children participating in the program**. Initial** _____

Agreement II: I certify that, ***(1)*** I agree to assume all risks in connection with my child's participation in the B2S, OST, and SC Programs and do hereby release, their employees, representatives, and volunteers from all liability and ***(2)*** that I bear the responsibility for carrying the appropriate medical and hospitalization insurance on the above named child. **Initial** _____

Agreement III: In case of an emergency, B2S has my permission to contact emergency personnel. The staff is authorized to administer first aid, emergency care, or take my child to the emergency room of the nearest hospital, and its medical staff has my permission to provide treatment as a physician deems necessary for the well-being of my child. Additionally, I will provide written permission for any medication that must be distributed to my child by the Program Staff. I understand medication will only be administered from an official pharmacy container with the child's name, dosage and doctor listed on the container. **Initial** _____

Agreement IV: B2S will notify me should my child become *ill* or *uncontrollable* and I will be responsible for picking up my child **immediately,** upon notification**. Initial** _____

Agreement V: I give permission for my child to attend any field trips while in the B2S. I authorize the use of insect repellant when needed. **Initial**_____

Agreement VI: I give my child permission to participate in swimming/water activities conducted, and authorize the use of sunscreen when needed. **Initial** _____

Agreement VII: I agree to inform B2S, both OST and/or SC program within 24 hours or the next business day, if my child or any member of the immediate household has developed any reportable communicable disease as defined by the Board of Health, except for life threatening diseases that must be reported immediately. **Initial**_____

Agreement VIII: **I understand and agree to pick up my child up from B2S Programs, by the designated times. Failure to pick up on time will result in a $5 per minute, per child fee. I also understand that the late fee has to be paid CASH before my child can return to the program. Initial**_____

Program hours are: During school 3:00 PM -- 6:00 PM; out of school 9:00 AM -- 4:00 PM.

Parent /Guardian Name (Print) _____ Date _____

Parent/Guardian Signature_____

Medical Information and Permission Form

Please list your reason(s) for wanting your child to attend Bridge 2 Success (**B2S**) *Out-of-School Time* (**OST**) or *Summer Camp* Programs (**SC**):

Describe your child using 5 words:
_____/_____/_____/_____/_____

Medication: Parents are required to advise B2S if your child is on prescribed medication. B2S will only administer medication prescribed by the participant's physician in the original container with signed parental permission.

Has your child ever been hospitalized for medical or psychiatric reasons: **(check one)** ☐ **yes** ☐ **no**

Hospital _____ Month/Year of Hospitalization _____
Reason _____

Date of last medical evaluation: _____

SCHOOL and FAMILY

Does your child experience any developmental, academic or behavior problems while in school with peers or teachers? **(check one)** ☐ **yes** ☐ **no**

If yes, please explain: _____

Describe any behaviors your child has demonstrated that cause for concern:

What usually makes your child feel safe? _____

Is there any other information regarding your child that you would like to share? _____

How did you learn about the B2S Out-of-School Time and Summer Camp Program?

Does B2S have permission to take photos of your child during activities?

Please check one: ☐ **Yes** ☐ **No** ☐ **Craft Projects Only**

Parent/Guardian Signature: _____

Date: _____

My Child's Allergies

Name:	

Food Allergies	
Allergic to:	Medication prescribed:

Natural/Seasonal Allergies	
Allergic to:	Medication prescribed:

Animals	
Allergic to:	Medication prescribed:

Medications	
Allergic to:	Medication prescribed:

Other Allergies	
Allergic to:	Medication prescribed:

Physician information	
Name:	
Address:	
Phone:	

Arkansas Department of Health
Immunization Registry (WebIZ)
Authorization to Release Official Immunization History

Patient/Client's Name: *(Last)*_____ *(First)*_____ *(Middle)*_____

Alias or Other Possible Name(s): _____

Date of Birth: *(M)*____/*(D)*____/*(Y)*____ ☐ Male ☐ Female Mother's Maiden Name: _____

Address: *(Street)*_____ *(City)*_____ *(State)*_____ *(Zip)*_____

****

Please indicate where to send this official immunization record.

Send official immunization record by: ☐ Walk-in /In Person ☐ Mail to address below

☐ Fax Number: (_____)_____-_____ ☑ Email: b2syouthcenter2@gmail.com

Name/Organization: Bridge 2 Success/Ministry of Intercession

Address: *(Street)* 3409 Baseline Rd *(City)* Little Rock *(State)* AR *(Zip)* 72209

Phone Number: (501) 565 - 0100

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Person requesting information please complete this section in full.

I_____ authorize the Arkansas Department of Health to release this patient/client's official immunization record from the Arkansas Immunization Registry (WebIZ).

Address: *(Street)*_____ *(City)*_____ *(State)*_____ *(Zip)*_____

Phone Number: (_____)_____-_____ Email: _____

REQUIRED: A copy of a valid, government-issued, photo identification document of the requestor is required for phone, fax, mail or email requests. No photocopy of photo ID required for walk-in requests.

Signature of Patient/Client:_____ Date: _____

(By signing here I declare I am authorized as either Self, Parent, Legal Guardian or Managing Conservator for a child)

****

Privacy Notification: Confidential communications about medical information or medical records from the Arkansas Immunization Information System at the Arkansas Department of Health may be communicated using an alternate means or be delivered using an alternate location. Under federal law 104-191, also known as HIPAA, a person is entitled to request such an arrangement upon written request. Under federal law, we are required to accommodate "reasonable" request for communicating confidential medical to you via alternate means. We may deny your request if we determine that your request is unreasonable. With your request, you agree that the security and confidentiality of your confidential medical information that we send to an alternate address or via an alternate means is your responsibility alone. If we act on your request and send communications as you have specifically directed us to do in writing, you agree that we cannot and shall not be responsible for any inadvertent disclosures that may occur as a result of fulfilling your written request.

****

For ADH Office Use Only

Date Searched/Released: _____ ☐ Record Released ☐ Record Not Found

By: _____ ☐ Record Found, but No Immunizations Reported

☐ ID Verified for walk-ins only (no copy of ID required)

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If you have any questions or concerns, please contact the Arkansas Department of Health's Immunization Section at 1-800-574-4040, via email at immunization.section@arkansas.gov or **fax to 501-661-2300**. You may reply by regular mail to your local Arkansas Department of Health clinic or to:

Arkansas Department of Health
Immunization Section, Slot 48
4815 West Markham
Little Rock, AR 72205

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WAIVER OF LIABILITY, ASSUMPTION OF RISKS AND INDEMNITY AGREEMENT

Waiver: In consideration for being permitted to utilize the Bridge 2 Success (B2S) facility, and the equipment contained therein, I, the undersigned participant, and, if under 18 years of age, my parent or guardian intending to be legally bound, do hereby for ourselves and our heirs, personal representatives, executors, administrators and assigns, **forever waive, release, discharge and covenant not to sue** B2S, its Board of Trustees, officers, administrators, faculty, staff, students, employees or agents **from liability for any and all claims and damages** that are the result of personal injury, accidents, illness (including death), or property loss that we or any of us may have, or that may hereafter accrue to us or any of us, arising out of or in connection with participants use of the B2S facility or the equipment contained therein.

Risks: While it is impossible to foresee all possible dangers, some of the specific hazards which might be encountered while utilizing B2S's facility and the equipment therein would include: falls, scratches, bumps, bruises, cuts, sprains, fractures, strains, internal injuries, broken bones, eye injury, joint injuries, back injuries, heart attacks, stroke, seizure, concussions, and other life-threatening injuries, including paralysis and death. **Assumption of Risks:** I have read the previous paragraphs and I understand the words and language in them. I have been advised of the potential dangers incidental to participating in B2S. With all such risks being known by me, I hereby voluntarily assume the risk of engaging in the use of B2S facility and the equipment contained therein, and further, accept full and complete responsibility for any injury, or accident, which may occur during my use of the B2S facility and the equipment contained therein.

Indemnification and Hold Harmless: I also agree to indemnify and hold B2S harmless from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney fees brought as a result of my participation in B2S, and to reimburse it for any such expenses incurred.

The participant further expressly agrees that the foregoing waiver and assumption of risk agreement is intended to be as broad and inclusive as is permitted by the law of the State of Arkansas and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

Acknowledgement of Understanding: I have read this waiver of liability, assumption of risks and indemnity agreement, fully understand its terms, and **understand that I am giving up substantial rights, including my right to sue.** I understand and agree that if I am signing this waiver of liability, assumption of risks and indemnity agreement on behalf of a minor child, I am giving up substantial rights for said minor child, including my right to sue. I acknowledge that I am signing the agreement freely and voluntarily and **intend by my signature to be a complete and unconditional release of all liability** to the greatest extent allowed by law.

I attest and verify that I am sufficiently physically fit to participate in the use of B2S facility and the equipment contained therein.

_____ _____

Participant's Printed Name Participant's Signature

_____ _____

Signature of Parent/Guardian of Minor Date

Participant Age (if Minor) _____

Emergency Contact Form *page 1 of 2*

Ensure that the information on this form is validated and updated periodically.

Personal Information	**Date when this form was filled or updated:**

Name: _____

Work Address: _____

_____

_____ _____ _____

City State Zip code

Home Address: _____

_____

_____ _____ _____

City State Zip code

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

E-mail (Home): _____ **E-mail (Work):** _____

Primary person to be notified in case of an emergency:

Name: _____

Relationship: **Relative** _____ **Friend** _____ **Other** _____

Home Address: _____ _____ _____ _____

Street Address City State Zip code

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

E-mail Address: _____

Secondary person to be notified in case of an emergency:

Name: _____

Relationship: **Relative** _____ **Friend** _____ **Other** _____

Home Address: _____ _____ _____ _____

Street Address City State Zip code

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

E-mail Address: _____

Insurance Information:	
Provider:	Contact person:
Reference No:	Phone:
List down any medications you take routinely and provide details:	
Details of any medical/mobility/mental health conditions that affect you currently or in the recent past.	
List any allergies that affect you & provide details:	
Any other information that emergency personnel should be aware of:	

The information requested on this form is confidential and for emergency use only. In the event of a medical emergency, this information will be used by Bridge 2 Success and emergency personnel.

Please ensure that the form has the most updated & accurate info.

In the case of emergency, I give permission for my information to be released to emergency personnel. I also agree that any of my emergency contacts listed on this form may be notified in an emergency, as needed.

Signature _____ Date _____

Youth Positive Prevention Program Services (PPP)

(Qualifying Criterial for Bridge 2 Success Participants)

All participants must meet a minimum of four (4) of the following:

Please check all that apply:

☐ Show signs of family instability

Coordinators Notes _____

☐ Exhibits emotional or behavioral problems

Coordinator Notes: _____

☐ Low socio-economic household

Coordinator Notes: _____

☐ Unstable living environment

Coordinator Notes: _____

☐ Lack of consistent food or meals

Coordinator Notes: _____

☐ Low academic performance or functioning below grade-level

Coordinator Notes: _____

☐ Enrolled in foster care (current or previous)

Coordinator Notes: _____

☐ Has a relative involved in the criminal justice system (current or previous)

Coordinator Notes: _____ _____

☐ Has a relative diagnosed with a documented mental illness

Coordinator Notes: _____

☐ Experienced trauma

Coordinator Notes: _____

☐ Use of alcohol, drugs or other substances

Coordinator Notes: _____

Parent Name: _____

Childs's Name: _____

Date: _____