Viking Zone Community Learning Center @ Ninth District

STUDENT REGISTRATION FORM

REGISTRATION INFORMATION

Student's Full Name: _____ | Grade: _____ | School: Ninth District

Gender: ☐ Male ☐ Female | Primary Language: ☐ English ☐ Spanish ☐ Other _____

Date of Birth: _____ | Student lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Legal Guardian

Parent/Guardian Name: _____ | Relationship to Student: _____

Home Address: _____

City: _____ | State: _____ | Zip Code: _____

Home Phone: _____ | Work Phone: _____

Cell Phone: _____ | Email: _____

EMERGENCY/MEDICAL INFORMATION

If I cannot be reached in the event of an emergency, the following persons are authorized to act in my behalf:

Name: _____ | Phone: _____ | Relationship to Student: _____

Name: _____ | Phone: _____ | Relationship to Student: _____

Physician's Name: _____ | Physician's Phone: _____

Does your child have any limitations or restrictions (special needs, allergies, medications, accessibilities, diet, etc.) we should know about? ☐Yes ☐No

If yes, please explain. (Please list all allergies.) _____

_____

DISMISSAL PROCEDURES

At the close of programming each day, my child: (PLEASE CHECK ONLY **ONE** OPTION)

☐ Will walk home alone.

☐ Will be picked up from school at 4:30 PM (PICK-UP OPTION "A").

☐ Will be picked up from school at 5:15-5:30 PM (PICK-UP OPTION "B"). **Please note that all students must be picked up by 5:30 PM. Failure to comply may result in removal from the program.**

☐ Will ride the late bus home. (If riding the bus, please choose **ONE** of the following sites as the drop-off location.)

- ☐ Greenup Street & Pleasant Street
- ☐ Greenup Street & Trevor Street
- ☐ E 13th Street & Scott Boulevard
- ☐ City Heights

PLEASE NOTE: If PICK UP OPTION "A" or PICK UP OPTION "B" is chosen, the child will only be released to an authorized adult. Authorized adults must present photo identification when picking up a student.

Please list those individuals authorized to pick up your child from programming:

Name: _____ | Phone: _____ | Relationship to Student: _____

Name: _____ | Phone: _____ | Relationship to Student: _____

Name: _____ | Phone: _____ | Relationship to Student: _____

Name: _____ | Phone: _____ | Relationship to Student: _____

Name: _____ | Phone: _____ | Relationship to Student: _____

OVER

CLC AGREEMENT

The Community Learning Center is offered as an extension of the school day to enhance learning for children by providing academic and enrichment opportunities. Covington Independent Public Schools/Covington Partners staff has full authority to operate the program at their discretion. We require and appreciate the cooperation of parents/guardians as we provide these opportunities.

By signing below, I understand and authorize that I WAIVE, RELEASE, AND DISCHARGE Covington Independent Public Schools, its employees, elected officials, officers, agents, insurance carriers, partners and representatives (collectively CIPS) from any and all liability, including but not limited to, liability arising from the negligence or fault of the entities or persons released, for my death, disability, personal injury, property damage, property theft, or actions of any kind which may hereafter occur during the Covington Summer Youth Program. I also agree to INDEMNIFY, HOLD HARMLESS, AND PROMISE NOT TO SUE the entities or persons being released— Covington Independent Public Schools (CIPS), and its employees, elected officials, officers, agents, insurance carriers, partners representatives and any other persons affiliated with or employed by CIPS--from any and all liabilities or claims made as a result of participation in the program, whether caused by the negligence of CIPS or any other related entity. FURTHERMORE, I CERTIFY THAT I HAVE READ THIS DOCUMENT, AND I FULLY UNDERSTAND ITS CONTENT. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT AND I SIGN IT OF MY OWN FREE WILL ON MY BEHALF AND ON BEHALF OF MY MINOR CHILD OR CHILDREN. I AM SIGNING IT FREELY AND VOLUNTARILY AND I UNDERSTAND I DO NOT HAVE TO SIGN IT. I UNDERSTAND THAT I HAVE A RIGHT TO REVIEW THIS DOCUMENT WITH MY ATTORNEY AND HAVE BEEN ENCOURAGED TO DO SO BY Covington Independent Public Schools

I ACKNOWLEDGE AND GIVE PERMISSION:

- For my child to take part in activities of the CLC "Viking Zone" at Ninth District Elementary, which may include off-site events, academic assistance, continuing education, clubs and recreational events.
- If a medical emergency arises, staff may take all steps necessary to ensure the safety of my child and all participants, including calling a public emergency vehicle for transport to an emergency facility. If a health condition currently exists or one would arise in the future which would impact the participation of my child, I will contact school staff immediately.
- My child may be removed from the program at any time due to my child's actions, inability to follow the guidelines given by the instructors, poor conduct, or reasons deemed appropriate by the program coordinator and CIPS staff;
- I am SOLELY responsible for the safety of my child at the conclusion of each program on any given day;
- If a medical emergency arises, CIPS and its employees can take all steps necessary to ensure the health and safety of my child and all other participants during the operation of the program;
- I will notify the program coordinator, in writing, about any changes to my child's registration information, including medical conditions, contact information, etc.;
- I have read, completed, and fully understand the Community Learning Center Behavior Contract;
- For the school to provide social and academic information about my child to Covington Partners (e.g. school attendance, semester grades, yearly test scores) and to use records to evaluate individual progress and improvement, as well as to evaluate the impact of the program on student achievement;
- Covington Partners and Covington Independent Public Schools have unlimited permission to use, publish, and republish my child's photograph or video image for purposes of promoting the mission of the organization(s) with or without identification of him or her by name.

_____

Parent/Guardian Name (Please Print)

_____ _____

Parent/Guardian Signature **Date**

OFFICE: Please return completed form to CLC Coordinator

CLC OFFICE USE ONLY

_____ Date submitted

_____ Date reviewed

_____ CLC Coordinator Initial

_____ Principal Initial

_____ Nurse Initial

Notes: _____

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