21st Century Schools
Participant Registration Form

****PLEASE PRINT****

FOR OFFICE USE ONLY

Date entered in Computer: ___/___/___

Staff initials ______

Participant Last Name: | Participant First Name: | Middle Initial:

Address: | City, State, Zip Code:

Home Phone: | Age: | Birth Date: | Gender (M or F):

School: | Teacher: | Grade:

Lunch Status:

☐ Full Price Lunch
☐ Reduced Price Lunch
☐ Free Lunch

Ethnicity: (check one)

☐ Caucasian American ☐ African American ☐ Native American
☐ Asian American ☐ Hispanic American ☐ Native Hawaiian/
☐ Multiracial ☐ Native Hawaiian/ Pacific Islander ☐ Other: ____________

Student Lives With:

☐ Both Parents ☐ Single Parent Mother ☐ Single Parent Father
☐ Guardian ☐ Mother/Stepfather ☐ Father/Stepmother
☐ Foster Care ☐ Other: ______________________________

Student Will:

☐ Walk Home
Release time: ______

☐ Be Picked Up

Is there any medical reason why your child shall not participate in certain physical activities?

☐ No ☐ Yes (If yes, explain below)

Please also list below anything else that the 21st Century Schools staff should know about your child.
(Examples: allergies, medications or special needs)

06/2018

Tazewell County Health Department

21st Century Schools
Participant Registration Form

****PLEASE PRINT****

Parent/Guardian #1 Last Name | First Name | Relationship

Home Phone | Work Phone | Cell/Other Phone

Parent/Guardian Email Address

☐ Check box if you would like to receive email notifications from the 21st Century Schools program

Parent/Guardian #2 Last Name | First Name | Relationship

Home Phone | Work Phone | Cell/Other Phone

In the event of an emergency, the parents/guardians will be contacted first. List 2 other adults to be contacted if the parents/guardians cannot be reached.

Emergency Contact #1 (Name, Phone) | Emergency Contact #2 (Name, Phone)

Adults Authorized to Pick-up Student: All the adults authorized to pick up must be over the age of 18. If you wish to have someone under the age of 18 pick up your student, you must provide separate written authorization to be kept on file.

☐All the adults listed above are authorized to pick up my child.
☐All the adults listed above with the exception of ______________________________ (Name) are authorized to pick up my child.

To list additional adults authorized to pick up your child, please use the lines below.

	Last Name	First Name	Phone	Relationship
1.				
2.				
3.				

I hereby wish to register my child in the 21st Century Schools program and indicate the above to be complete and accurate.

Signature of Parent/Guardian ______________________________ **Date** ____________________

21st Century Schools
AGREEMENT TO TERMS AND CONDITIONS

Student Name: ______________________________

Enrollment Agreement: I have received, read and fully understand all the Policies and Procedures contained in the 21st Century Schools Parent Handbook. I hereby agree to abide by all the Policies and Procedures therein. I further give my consent to the school district and 21st Century Schools to share participant records with each other for the purposes of providing educational support and assistance. In addition, I understand that participant records will be used to evaluate individual progress and improvement, as well as to evaluate the impact of the program on student achievement and to obtain continued funding for the program. In conclusion, I wish to enroll my child in the 21st Century Schools program offered by the Tazewell County Health Department.

______________________________ ______________________________

Signature of Parent/Guardian **Date**

- -

Internet Usage: I am familiar with and understand my child's School District Internet Policy. I understand that the same terms and conditions listed in the District's Internet Policy apply during Internet usage while in the 21st Century Schools program. Internet access is designed for educational purposes and the District and TCHD have taken precautions to eliminate controversial material. However, I also realize it is impossible for the District and TCHD to restrict access to all controversial and inappropriate materials. I will hold harmless the District, TCHD, their employees, agents, or board members for any harm caused by material or software obtained via the network. I accept full responsibility for supervision if and when my child's use is not in a school setting. I have discussed the terms of authorization with my child. I hereby request that my child be allowed access to the Internet on a district computer during time spent at the TCHD program.

______________________________ ______________________________

Signature of Parent/Guardian **Date**

- -

Photo Release: I give my permission for 21st Century Schools to use pictures or videos, either taken by staff, newspaper or television photographers, in the promotion of the afterschool program.

______________________________ ______________________________

Signature of Parent/Guardian **Date**

- -

Movie Agreement: I understand that movies will be watched during the 21st Century Schools program. There will be times that a PG movie may be viewed. If there are particular movies that you do not want your child to view, please notify our staff in writing. I will hold harmless the District, TCHD, their employees, agents, or board members for any harm caused by materials obtained during the viewing of the movie. I accept fully the responsibility for allowing my child to view these movies. I hereby request that my child be allowed access to view these movies during the time spent in the before and afterschool programs.

______________________________ ______________________________

Signature of Parent/Guardian **Date**

21st Century Schools
EMERGENCY MEDICAL CONSENT

Child's Full Name: ______________________________ Birth Date: ____________________

In the event that my child requires medical and/or surgical care while I'm unable to be reached, I hereby give my consent for medical and/or surgical treatment for the child listed above. I agree to pay all costs and fees contingent for any emergency medical care and/or treatment for my child as secured or authorized under this consent. 21st Century Schools will make every effort to notify parents and guardians immediately in case of emergency.

STUDENT MEDICAL INFORMATION

Doctor: ______________________________ Doctor Phone #: ____________________

Address of Doctor: ______________________ Date of last Tetanus Shot: ____________

Hospital Preference: ____

Allergies:

____

____

Medications:

____

____

I authorize the 21st Century Schools staff to apply the following topical care items to my child as needed:

☐ Triple Antibiotic Ointment ☐ Sunscreen ☐ Bug Repellant

This consent will be in effect beginning on (date) ______________________ and will continue while the child above is enrolled in this facility.

______________________________ ______________________________
Signature of Parent/Guardian **Date**

06/2018

CORNERSTONE INFORMED CONSENT FORM

Name of Participant: ______________________ ______________________ ______
(Last) (First) (M)

Date of Birth: ________ ________________ Male ______ Female ______
(Month) (Day) (Year)

Participant's ID Number ______________________________

It is important that you read the following. If there is anything that you do not understand, or if you have any questions, be sure to ASK.

Welcome to Cornerstone, a system that collects data on a wide range of health care services to individuals. These services include WIC (Women, Infants and Children); Immunizations; Case Management; Prenatal and Postpartum Care; Pediatric Primary Care; Early Intervention; Breast and Cervical Cancer; Diabetes Control; and Healthy Families Illinois.

We are asking for permission to collect information about the participant and store it in a centralized computer system maintained by the Illinois Departments of Human Services and Public Health. Based on the information collected during the enrollment or registration process, we will determine whether you need further service. Only those authorized health care professionals with a direct need to know about you will have access to this information. Information may be released for service authorization, audit, and evaluation purposes. Necessary information, without any client's name, will be sent to federal agencies that fund these programs.

By signing this consent form, you agree to allow certain information to be collected by this agency/clinic. The person(s) receiving this information has a legal and ethical duty to keep the information confidential and private and not release it to anyone else without your written permission unless the law allows it.

A. I authorize ________(Cornerstone site) to collect information during the enrollment/registration process.

B. This authorization covers all the medical, social and financial information about the participant, including: participant background and demographic information; health visit information; medical and developmental history; prenatal, birth, and postpartum data; infant/child visit data; immunization records; participant risks; problems or factors that prevent the participant from receiving proper medical care; appointments made and services received; goals and care plan; WIC food packages; program information; information required by the federal Maternal and Child Health Block Grant Program, and Early Intervention. Any information you do not want released should be written in Part D.

C. This authorization also covers information about mental health, AIDS, HIV, sexually transmissible diseases, alcoholism, and drug use, which may be reported by me. I understand that I am not required to report or discuss those matters with anybody.

D. The following information I do NOT want to be shared:

E. I am making this consent within the limits of my legal authority. I understand that I may revoke this consent orally or in writing at any time, but that revoking this consent will not cancel what was done before I revoked it. I also understand and agree not to hold the Illinois Departments of Human Services and Public Health liable for the release of any information about me in accordance with the terms of this consent form.

F. A photostatic copy/facsimile of this consent will be as valid as the original

For child participant:		For adult participant:
______________________________	OR	______________________________
Signature of parent/legal guardian/caretaker /Date		Signature of adult participant / Date

Signature of Witness: ____________________ Date: ____________________

(06/07)