MCS-781 03/15

STUDENT ACTIVITIES DEPARTMENT
EXTENDED CARE/HOMEWORK CLUB
REGISTRATION 2019-20

Please circle your child's grade: K-2nd 3rd-4th grade 5th-6th grade

Please circle your desired session(s): AM Session PM Session AM & PM Session

TRANSPORTATION INFORMATION

	MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY	
Location:	**AM**	**PM**	**AM**	**PM**	**AM**	**PM**	**AM**	**PM**	**AM**	**PM**
HOME										
NON-RESIDENTIAL PARENT										
CAR RIDER										
EXTENDED-CARE										

Start Date: _____

Student Name: _____ ID: _____

Grade (19-20): _____ Date of Birth: _____ Male/Female _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____

Mother/Guardian Name: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Address if different than child: _____

Father/Guardian Name: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Address if different than child: _____

- **$60 Non-Refundable** registration fee (per family) is due upon registration
- **$100 Refundable** fee for either AM or PM (per student) is also due upon registration
- **$150 Refundable** fee for both AM and PM (per student) is also due upon registration

I agree to pay $6.00 per hour with a minimum of 5 hours per session each week for my child. Payments are due on a weekly basis. If payment is late, a 10% late fee will be added.

I agree to give a two week notice if I find it necessary to remove my child before the school year ends.

_____ _____

Parent/Guardian Signature Date

Combined Parent Permission & Emergency Medical Authorization
Extracurricular, Co-curricular and Athletics Permission Section
(both the PERMISSION section and EMA require signatures)

Event/Activity: _____ **Date:** _____

PERMISSION - This permission slip is for participation in the above referenced activity. This activity will be supervised by the Mason City Schools staff.

We, the undersigned do hereby give permission for our child to participate in the above stated activity. We do hereby assume full responsibility for any risk of bodily injury, personal injury or mental injury or death due to our child's participation in these activities and the necessary travel to and from any activity site. We also further hereby assume full responsibility for all lost, stolen, or damaged personal property and will not hold the school or its employees responsible for said loss or damage to personal property.

The undersigned further release, waive, discharge and covenant not to sue the Mason City School District Board of Education, its individual members, its superintendent, principals, administrators, employees, agents or anyone acting on its behalf, from all liability, arising from or by reason of any bodily injury, personal injury or mental injury, known or unknown, including death, resulting from, or to result from our child's participation in field trips and co-curricular activities with Mason City School District.

We expressly agree that this release is intended to be as broad and inclusive as permitted by the laws of the State of Ohio or any other state in which said student may be injured and that if any portion of this release is held invalid, it is agreed that the balance shall, nevertheless, continue in full force and effect. We further state that we have fully and carefully read the above release and know the contents of the same and sign this release as our own free act. We further consent to emergency treatment by a physician in the event of injury to or illness of our child during his/her participation in such activities.

*****PARENT GUARDIAN SIGNATURE*****: _____ ***Date:*** _____

↑ ↑ ↑

EMA SECTION - *EMERGENCY MEDICAL AUTHORIZATION*

MCS-201 Rev 12/10

Student Information:

Student Name: _____ Date of Birth: _____ Grade:_____ Teacher/Team: _____

Mother Name: _____ Phone: _____ (day/night) Cell: _____
(Circle one)

Father Name: _____ Phone: _____ (day/night) Cell: _____
(Circle one)

Is there a legal custody order that applies to this child? Yes or No

If yes, please submit a copy of the final custody/guardianship papers to the district registrar or the guidance department in your child's building.

Emergency Contacts *(if parent/guardian cannot be reached):*

Name: _____ Relationship: _____ Phone (Cell): _____

Name: _____ Relationship: _____ Phone (Cell): _____

Name: _____ Relationship: _____ Phone (Cell): _____

Emergency Care Information:

Preferred Physician: _____ Phone: _____ Fax: _____

Preferred Dentist: _____ Phone: _____ Fax: _____

Preferred Hospital: _____ Location: _____ Phone: _____

(Alternate hospital may be selected at the discretion of the responding Emergency Medical Services personnel)

Allergies and/or Specific Health Considerations: _____

(Health Alerts related to dietary concerns must be communicated directly to MCS Office of Child Nutrition by the parent or guardian)

Medications taken by student on a daily or frequent basis: _____ _____

PLEASE SIGN ONLY ONE OF THE FOLLOWING PARENT/GUARDIAN SIGNATURE LINES:
PART I – TO GRANT CONSENT

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted: _____

_____

Signature of Parent/Guardian or Student if Age 18: _____ ***Date:*** _____

Address: _____

*****PLEASE SIGN PART I OR PART II*****

PART II - REFUSAL TO CONSENT *(Complete only if action described above is refused)*

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action: _____

Signature of Parent/Guardian or Student if Age 18: _____ ***Date:*** _____

Address: _____

*****PLEASE BE SURE YOU HAVE SIGNED THE PERMISSION AND EMA SECTION OF THIS DOCUMENT*****

Student Health History

Student's Last Name: _____ First: _____ Middle _____

Circle One: Male or Female Birth Date: _____

Family History – (please list child's brothers and sisters)

	Name	Birth Date	Sex		Name	Birth Date	Sex
1				4			
2				5			
3				6			

Allergies (please list and describe allergies or reactions)

Medications:
Foods / Plants / Animals / Other:
Recommended treatment for severe reaction:

Injuries and Illnesses (please list any severe injuries or illnesses)

Injury / Illness	Age of Child	Hospitalized ?

Additional Information

What medications are given daily?
What medications are given frequently, but not daily?
This child is usually (circle one): very active normally active rather inactive

Do you have any other comments or concerns about this child's health or development that you would like the school to be aware of ? If yes, please explain briefly._____

_____

Health Conditions (please check any that this child has had):

- ❑ Abnormal spinal curvature
- ❑ Allergy (Environmental)
- ❑ Allergy (food)
- ❑ Allergy (seasonal)
- ❑ Anemia
- ❑ Asthma or wheezing
- ❑ Behavior/emotional
- ❑ Birth/Congenital – Malformation
- ❑ Bleeding Disorder
- ❑ Cancer
- ❑ Chicken Pox Date of Disease _____
- ❑ Chronic diarrhea /constipation
- ❑ Concern about relations w/siblings or friends
- ❑ Cystic fibrosis
- ❑ Diabetes
- ❑ Ear/Hearing
- ❑ Emergency Care/Trauma
- ❑ Eye/Vision
- ❑ Frequent headaches
- ❑ Frequent sore throat
- ❑ Frequent stomach discomfort
- ❑ Heart disease
- ❑ Hepatitis
- ❑ Incontinence/ bladder
- ❑ Incontinence/Bowel
- ❑ Kidney disease
- ❑ Lactose/dairy intolerant
- ❑ Meningitis/Encephalitis
- ❑ Nervous twitches /tics
- ❑ Rheumatic fever
- ❑ Seizures or epilepsy
- ❑ Sickle cell disease
- ❑ Skeletal/joint condition
- ❑ Skin Condition
- ❑ Substance abuse(alcohol or drugs)
- ❑ Suicide attempt
- ❑ Toothaches / dental infections
- ❑ Urinary tract Infections
- ❑ Other: _____

Is this child currently receiving care through a hospital? Yes or No Name of hospital _____

Form Completed By: _____ Relationship to Child: _____

By signing below, I give permission for any and all medial information to be shared with all school personnel that may interact with my child.

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

Extended Care/Homework Club
Mason City Schools
Student Activities Department

The following people have permission to pick my child up without any further written permission.

Parent/Guardian Signature _____ Date_____

Student name _____

Home address _____

Mother's name _____

Work phone _____

Company/business name _____

Cell phone _____

Home phone _____

Father's name _____

Work phone _____

Company/business name _____

Cell phone _____

Home phone _____

Family/Friend Name _____

Work phone _____

Company/business name _____

Cell phone _____

Home phone _____