Club Esteem Member Registration Form 2020-2021

Circle what you would like your child to participate in:
Virtual After School Program **On -Site** – Lipscomb **Both - Virtual and On - Site**
Expansion Tutoring Site - Joseph N. Davis Community Center (formerly Grant Street) or West Melbourne location

MEMBER INFORMATION: (Please print clearly)

First name: _____ Last name: _____

Nick name: _____

Age: _____ Date of Birth: _____ Gender: M F

Grade entering in **August 2020**:_____School: _____

Circle your child's School of choice: E- Learning Brevard Virtual Schools Part Time Full Time

***Expected arrival time of your child**: _____ Is your child a returning member? Yes ☐ No☐

*Are there days and times your child will not attend our program? Yes ☐ No ☐

If yes, please list days and times _____

If your child participated in our On-Site after school program, will your child walk or ride a bicycle to and from Club Esteem? Yes ☐ No ☐

Has your child ever been retained? Yes No If yes, in what grade? _____

Club Esteem Special COVID-19 Program Hours - Elementary: Monday – Friday 2:45PM - 6:30PM **Middle and High School:** Monday - Friday 3:30-6:00PM

List all enrichment activities you would like for your child to participate in:

STEM –Coding, Robotics, or Sea Perch Math Girl Scouts Reading Sign Language Logics & Problem Solving Goal Setting Character Development & Motivational Talks Mental Health Drawing/ Painting (circle one) Making of a Fine Young Lady Just for Gents Cool Cops (all ages)

Teens as Tutors (9th-12th 3.0 GPA higher) Future Professionals of Club Esteem/College Prep (9th-12th)

* **Are there any concerns/special needs regarding your child that we should be aware of?** Yes ☐ No ☐

If yes, what are they? _____

List the people who you grant permission to pick up your child: **(You may use the back if you need additional room).**

Name_____ relationship to child _____

Name_____ relationship to child _____

PARENT/GUARDIAN INFORMATION:

Name: _____

Address: _____ City & State: _____ Zip: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Email: _____

Please read and sign below:

I authorize Club Esteem to access my child's school records and speak to his/her teacher and or counselor concerning my child's behavior and or academic progress.

_____ _____

Parent's Name (Please Print) (Parent's Signature)

_____

(Today's Date)

CE Form A
Aug 2020
EL

Club Esteem Inc., Emergency Contact and Medical Information Form

Child's Name | Date of Birth | M F Sex

Parent's/Guardian's Name | Parent's/Guardian's Name

( ) Home Phone | ( ) Cell Phone | ( ) Home Phone | ( ) Cell Phone

Address | Address

City, ST ZIP Code | City, ST ZIP Code

Alternative Emergency Contacts

Primary Emergency Contact | Secondary Emergency Contact

( ) Home Phone | ( ) Cell Phone | ( ) Home Phone | ( ) Cell Phone

Address | Address

City, ST ZIP Code | City, ST ZIP Code

Medical Information

Hospital/Clinic Preference

Physician's Name | Phone Number

Insurance Company | Policy Number

If I/my child is injured, becomes ill, or needs medical attention for any reason, this authorizes program staff to assist me/my child and to call for medical assistance. I wish myself/my child to be transported to _____ (name of medical facility), when possible. I understand I am responsible for all costs incurred in any such medical emergency.

Allergies/Special Health Considerations: Does your child have any of the following conditions or a history of the following conditions? **(Check all that apply.)** □ asthma □ diabetes □ convulsions/seizures □ migraine headaches □ bronchitis □ ear infections □ fainting spells □ heart or cardio-vascular problems/disease □ chronic bone, muscle or joint problems other condition(s): (Please list)_____

MEDICAL EMERGENCY PARENTAL PERMISSION:
If an injury or other medical condition occurs, I hereby give permission to Club Esteem staff or volunteer to provide routine health care and seek emergency treatment. I authorize all medical and surgical treatment, including X-rays, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. I agree to the release of any record necessary for treatment, referral, billing or insurance purposes. I am aware that I am financially responsible for charges and hereby guarantee full payment to the attending physicians or health care unit. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

Parent's/Guardian's Signature | Date

Witness Signature | Date