



AFTER-SCHOOL PROGRAM

2011/12 School Year

APPLICATION FORM

Accepting students from Amherst Street, Broad Street, Dr. Crisp, Fairgrounds Elementary, Ledge Street, Sunset Heights and as well as Pennichuck Middle School, Fairgrounds Middle School and Elm Street Middle School.

School: _____ Grade: _____

Student Name: _____ Sex: _____ Age: _____

Address: _____

City/State/Zip: _____

Birthdate: _____

Parent/Guardian: _____

Home Phone #: _____ Cell Phone # _____

Work Phone #: _____ E-mail: _____

**Please fill out this application form and first week's payment of \$35.00.
Student will not be enrolled until first payment is received.**

Mail applications to: The Salvation Army
Attention: Tyler Crowell
1 Montgomery Avenue
Nashua, NH 03060

For more information please call Tyler at 603 889-5151 ext. 16.



AFTER SCHOOL PROGRAM

PERMISSION FORM TO TRANSPORT CHILD FROM SCHOOL

I give permission to The Salvation Army After School Program to pick up or arrange bus

transportation for my child, _____
(name of child)

from _____ at the following time _____ and
(name of school)

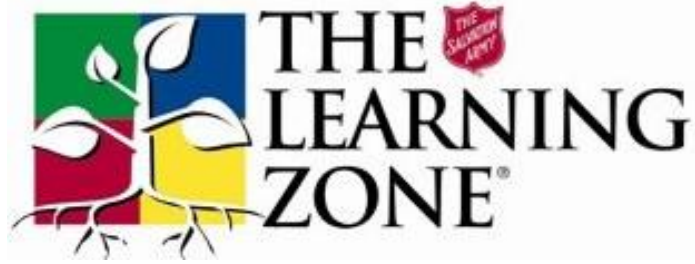
Transport them to The Salvation Army, 1 Montgomery Avenue, Nashua, NH 03060.

Signature of Parent/Guardian: _____ Date: _____



SEVERE WEATHER POLICY

In case of severe weather, please listen to **WMUR TV Channel 9** for school closing announcements. When the Nashua Public Schools are closed for the day or have an early release due to weather, the Learning Zone will also be closed.



AFTER SCHOOL PROGRAM

PICK-UP AUTHORIZATION FORM

I understand that I or a properly designated person **MUST** pick up my child at The Salvation Army located at 1 Montgomery Avenue, Nashua, NH no later than 6:00 P.M.

I give permission for the following people to pick up my child. I understand that they will have to show a photo ID in order to pick up my child. I understand my child will not be released to anyone except those listed on this form.

Name: _____

Phone #: _____

Relationship: _____

Name: _____

Phone #: _____

Relationship: _____

Name: _____

Phone #: _____

Relationship: _____

Name: _____

Phone #: _____

Relationship: _____

Name: _____

Phone #: _____

Relationship: _____

The following person/people cannot pick up my child.

Name: _____

Relationship: _____

Name: _____

Relationship: _____



AFTER SCHOOL PROGRAM

PERMISSION TO ADMINISTER MEDICATION

Prescription Medication:

The Learning Zone staff is not permitted to administer any prescription medication.

Non-Prescription Medication:

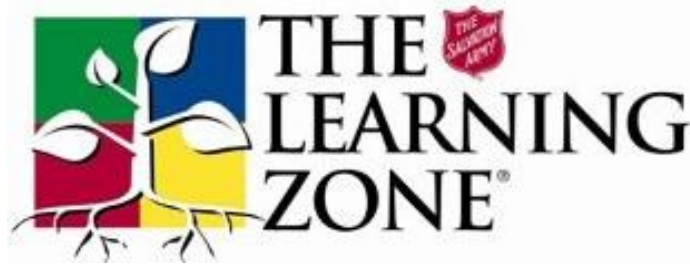
From time to time children will complain about headaches, aches and pains, and rashes. If you want your child to take something on those occasions, **you must provide the medication in its original container.** We will put your child's name on it and keep it in the first aid kit. We will contact you with each occasion we use it so that you are aware.

You must sign below if you want us to give either to your child if the need arises. (We will always call you before we give it to the child).

_____Acetaminophen

_____Ibuprofen

Signature of Parent/Guardian: _____ Date: _____



AFTER SCHOOL PROGRAM

MEDICAL FORM

Name of Child: _____ Date of Birth: _____

1. Name of Emergency contact: _____

Relationship to child: _____ Phone Number () _____

2. Name of second emergency contact: _____

Relationship to child: _____ Phone Number () _____

Family Doctor: _____ Phone Number: () _____

Address: _____

Family Dentist: _____ Phone Number: () _____

Address: _____

EMERGENCY TREATMENT

_____ I give The Salvation Army permission that in the event I cannot be reached in an emergency, permission is given to the hospital, physicians, and qualified medical personnel, to give proper treatment to my child. This includes injection, medication, and emergency surgery if needed.

_____ I do not give permission to The Salvation Army for emergency medical or dental care. In the event of an illness or injury, which requires emergency medical or dental treatment, I wish the following action to be taken _____

Parent/Guardian Signature: _____ Date: _____

CHILD HEALTH RECORD

Please indicate the conditions that have affected your child:

| | | |
|--|--|----------------------------------|
| <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart defect/disease | <input type="checkbox"/> Ivy Poisoning | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Bleeding/clotting | Allergies to: |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> German Measles | Plants: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mumps | Foods: _____ |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Hay Fever | |
| <input type="checkbox"/> Penicillin Allergy | List other drug allergies: _____ | |

List any operation or serious injuries & Dates: _____

List any disability or chronic recurring illness: _____

List any current medications your child is using: _____

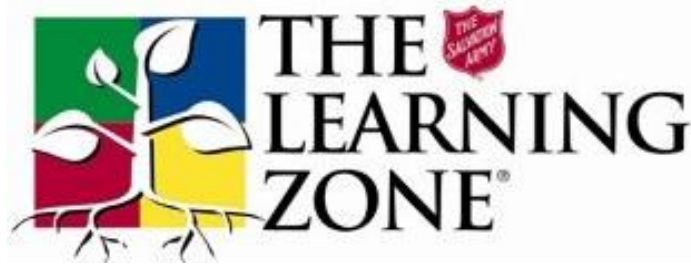
Make us aware of any other health/behavior concerns that will affect your child: _____

IMMUNIZATION AND INFECTIOUS DISEASE HISTORY COPY HERE OR ATTACH A COPY

| | D/M/Y | D/M/Y | D/M/Y | D/M/Y | D/M/Y | D/M/Y |
|----------------------|-------|-------|-------|-------|-------|-------|
| Polio-Oral (OPV) | | | | | | |
| Polio-Salk (OPV) | | | | | | |
| Diphtheria (DPT) | | | | | | |
| Tetanus (DPT) | | | | | | |
| Whooping Cough (DPT) | | | | | | |
| Measles (MMR) | | | | | | |
| Mumps (MMR) | | | | | | |
| Rubella (MMR) | | | | | | |
| Chicken Pox | | | | | | |
| Scarlet Fever | | | | | | |
| HIB | | | | | | |

I HEREBY STATE THAT THE INFORMATION PROVIDED ON THIS MEDICAL FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. THE CHILD DESCRIBED ABOVE HAS MY PERMISSION TO ENGAGE IN ALL PRESCRIBED CENTER ACTIVITIES EXCEPT AS NOTED.

Signature of Parent/Guardian: _____ Date: _____



AFTER SCHOOL PROGRAM

Date of Enrollment: _____

Name of Child: _____ Date of Birth: _____

Age: _____ Grade: _____ School Attending: _____

Transportation: _____ Bus _____ Van

_____ Application Form

_____ Medical Form

_____ Permission to Administer Medication

_____ Pick-Up Authorization Form

_____ Permission Form to Transport Child from School

_____ Permission for Photography/Videotaping/And for Student Internet Access

_____ Payment Agreement

_____ Permission to Obtain Interim Reports and Grade Cards

_____ Information Form for Foundations



AFTER SCHOOL PROGRAM

PERMISSION TO OBTAIN **SCHOOL INTERIM REPORTS AND GRADE CARDS**

Dear Parents:

We are asking that you allow us to have a copy of the interim reports and grade cards of your child. It is our hope that this will allow us to serve you and help your child with study habits, and areas that may need more concentration.

Thank you very much for your cooperation, and God Bless.

Tyler Crowell
The Salvation Army After-School
Program Director

CONSENT FORM

I _____, the parents/guardian of _____,

Student at _____ elementary/middle school, give my

consent for the school to release interim reports as well as copies of grade cards to The

Salvation Army After-School Program, Tyler Crowell, Director. Thank you.

Signature of Parent/Guardian: _____ Date: _____



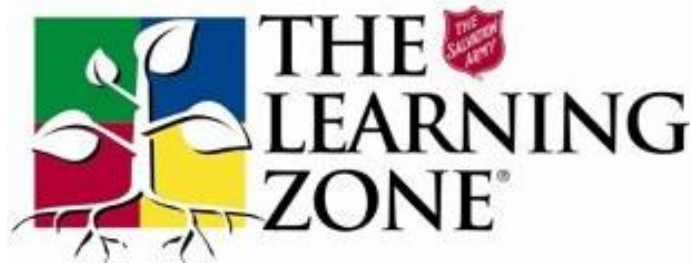
AFTER SCHOOL PROGRAM

INFORMATION FOR FOUNDATIONS AND GRANTS

Many of our funds for running the program come from Foundations and Grants. These foundations require data (figures) given to them concerning the program, and the people it serves. It is for this reason that I ask the following questions:

1. How many children in your family? _____ Adults? _____
2. What is your average income? _____
(Circle one: monthly, weekly or yearly)
3. Does your child/children qualify for free or reduced lunch? ___yes ___no
4. What is your Ethnic background: ___American Indian, ___Hispanic,
___African American, or ___Caucasian

Thank you for your understanding and cooperation in this very important matter.



AFTER SCHOOL PROGRAM

PAYMENT AGREEMENT

I understand that the weekly fee for The Learning Zone is \$35.00.

I understand that payment is due the Monday prior to the week my child will be attending. (example: if your child is planning on attending the week of 9/12 payment is due by 9/5)

I understand that if I am receiving state assistance, it is still my responsibility to complete and sign the state form every Friday as well as pay my portion of the fee that I am responsible for.

I understand that if I get behind more than three payments my child will not be able to continue in the program until payments are caught up.

I understand that there is a \$15.00 charge for all returned checks.

I have read the payment agreement and understand it is my responsibility to comply with the items listed.

Signature of Parent/Guardian: _____ Date: _____

Please make checks payable to: The Salvation Army. Please write your child's name on the check and the week you are paying for. If you are paying cash, please put the money in an envelope with your child's name on the outside of the envelope and the week you are paying for. Thank you.

If you have any questions, feel free to contact Mary Ann Picard at 889-5151 x 14.