

Boys & Girls Club of Trenton & Mercer County

PHOTO/VIDEO/INTERVIEW CONSENT

(To be completed by the parent or guardian)

I certify that I am the parent or legal guardian of _____, whose
date of birth is _____. name of child
month/day/year

I understand that this after-school program features special events both in-school and away from school. Media representatives, newspaper and television reporters, photographers, and public-relations personnel may be present at these special events to record them. In some cases they may interview and/or photograph children who participate in these events. These photographs, videos, and interviews will only be used to promote this after-school program.

I give permission for my child to be photographed or otherwise recorded during after-school events and activities, and for any and all such photographs to be displayed by Boys & Girls Club of Trenton & Mercer County and/or New Jersey After 3 in any medium (books, newsletters, web sites, etc.), whether now or hereafter known or developed.

SIGNATURE OF PARENT OR GUARDIAN

DATE

If you do not wish for your child to participate in the activities described above, please review this section of this form.

I DO NOT give permission for my child to be photographed or otherwise recorded during after-school events and activities. As a result, my child may not be able to participate in these events and activities.

SIGNATURE OF PARENT OR GUARDIAN

DATE

Boys & Girls Club of Trenton & Mercer County

HEALTH RECORD (To be completed by the parent or guardian)

This confidential health record will only be used to ensure the safety of the children in this program. This information will not be shared outside of this after-school program. Feel free to continue your notes on back of this form.

Student's Name:

Date of Birth:

1 . Please provide your child's medical history.

CONDITION	YES (if yes, write approx. date)	NO
Asthma	<input type="checkbox"/> _____	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/> _____	<input type="checkbox"/>
Diabetes	<input type="checkbox"/> _____	<input type="checkbox"/>
Ear Infections	<input type="checkbox"/> _____	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/> _____	<input type="checkbox"/>
Measles	<input type="checkbox"/> _____	<input type="checkbox"/>
German Measles	<input type="checkbox"/> _____	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/> _____	<input type="checkbox"/>
Mumps	<input type="checkbox"/> _____	<input type="checkbox"/>
Corrective Device (glasses, hearing aid, etc.)	<input type="checkbox"/> _____	<input type="checkbox"/>
Does your child use an inhaler?	<input type="checkbox"/> _____	<input type="checkbox"/>

ALLERGY	YES	NO
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Insect Stings	<input type="checkbox"/>	<input type="checkbox"/>
Foods	<input type="checkbox"/>	<input type="checkbox"/>
Plants	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Topical ointments	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
If "yes" to any of the above, please specify allergy and describe reaction.		

2 . List significant illnesses or surgeries. Provide the date and any instructions.

3 . Special situations or needs that program staff should be aware of:

<input type="checkbox"/> Child has behavioral/emotional difficulties
<input type="checkbox"/> Child has physical disabilities
<input type="checkbox"/> Other (describe)

4 . Special Health Care Needs

Does your child have special health care needs that require treatment and/or medication? YES NO

If yes, describe below. If your child requires treatment and/or medication during after-school hours, complete the *Health Care Plan for a Child with Special Health Care Needs* form.

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5 . Medication

Does your child take medication for any condition or illness? YES NO If yes, describe below.

If your child requires medication during after-school hours, complete the *Medication Consent* form.

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6 . Sunscreen and Topical Ointments

Do you give permission to the after-school program to apply sunscreen or other over-the-counter topical ointments on your child? YES NO

7 . Activities to be encouraged:

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8 . Activities your child cannot participate in:

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9 . My child may participate in all program activities, except those noted in number 8 above.

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Parent/Guardian Signature

Date

Boys & Girls Club of Trenton & Mercer County

EMERGENCY MEDICAL CARE (To be completed by the parent or guardian)

Student's Name: _____ **Date of Birth:** _____

- 1. If my child requires emergency medical care and I cannot be reached, I give my consent to the above after-school program to obtain the necessary medical care for my child. I agree to pay all of the costs associated with the emergency medical care that my child receives. I understand that every effort will be made to contact me before and after medical care is provided.**
- 2. This information is strictly confidential and will not be shared with anyone without my written consent or in the case of emergency medical care.**
- 3. Following emergency medical care, my child may be released to the following people:**

Name: _____ Relationship to Child: _____
Address: _____ Employer: _____
Home Phone: _____ Work Phone: _____

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4. Health/Insurance Information:

Student's Doctor: _____ Insurance Company: _____
Phone: _____ Policy Holder's ID: _____
Allergies: _____ Religious Preference: (optional) _____
Last Tetanus: _____ Medication(s) being taken: _____
Address
(student's doctor): _____

Additional Comments: _____

- 5. I understand that this consent will be in effect as of the date of my signing this form and will continue as long as my child is enrolled in this after-school program.**

Parent/Guardian Signature

Date

Name

Relationship to Child

Telephone

DO NOT RELEASE MY CHILD TO THE FOLLOWING PEOPLE:

Name Relationship to Child

Name Relationship to Child

EMERGENCY CONTACTS

Please identify two persons who may be called between 3:00pm and 6:00pm if you are not available.

First Name Last Name

First Name Last Name

Relationship to Student

Relationship to Student

Home Phone

Home Phone

Work Phone

Work Phone

Other Phone

Other Phone

Street Address

Street Address

City State Zip

City State Zip

INFORMATION ABOUT CHILD

What are your child's interests? _____

Are there any particular areas on which you would like the program to focus (i.e. math, social skills, health awareness)?

I allow the school to release to the New Jersey After 3 program, information about my child's school performance, including, but not limited to, grades and test results. Yes No

PARENT/GUARDIAN SIGNATURE

I give my child permission to participate in the afterschool program.

Parent/Guardian Signature

Date