

TRINITY LUTHERAN CHURCH
BEACON AFTER SCHOOL PROGRAM REGISTRATION FORM 2024-25

(Please Print)

| STUDENT INFORMATION | | |
|---|--|---|
| Student's name: Preferred/Nickname: | | |
| Birth Date: | Age: | Gender: <input type="checkbox"/> M <input type="checkbox"/> F |
| Street Address: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both <input type="checkbox"/> Other _____ | City: | Zip: |
| Mother's Name or Custodial Parent/Guardian (please circle): | Phone: Texting Ok? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Beacon uses <i>Remind</i> to send messages to keep parents informed. Please provide an email address if you do not text or wish to receive both text and email: | | |
| Father's Name or Non-Custodial Parent/Guardian (please circle): | Phone: Texting Ok? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Beacon uses <i>Remind</i> to send messages to keep parents informed. Please provide an email address if you do not text or wish to receive both text and email: | | |

| SCHOOL INFORMATION | | |
|--------------------|--------|----------|
| School: | Grade: | Teacher: |

| MEDICAL HISTORY AND HEALTH INFORMATION | |
|--|---|
| Physician's Name: | Office Phone: |
| Medical Insurance Co.: | Policy No.: |
| If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability, or condition to which your child is subject and of which the staff should be aware and of what, if any, action of protection is required on account thereof. Please include the names of medications and dosages that must be taken. | |
| Allergies (environmental, food, medication, insect, other): | |
| Health concerns (asthma, epilepsy/seizures, heart trouble, diabetes, frequent upset stomach, physical handicap, toileting issues, ADD/ADHD, other): | |
| Medications: | |
| Are immunizations up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No | Date of last tetanus immunization: |
| Please initial each statement indicating you have read and understand it. | |

| | |
|---|--|
| <p>_____</p> | <p>The undersigned has legal custody of the minor named above and has given consent for him/her to attend the events organized by Trinity Lutheran Church's Beacon After School Program. In the event of an emergency, this form gives permission to seek whatever medical attention is deemed necessary by a licensed physician, and releases the church and its staff of any liability against personal losses of named minor. This form also serves as authorization to permit named minor to receive emergency medical attention when needed. If I or my emergency contacts are unavailable to give consent, I affirm that the health insurance information is accurate as of the signed date and will, to the best of my ability, remain in effect for the named minor. In the event that medical treatment is required, I acknowledge that I am responsible for the cost of any medical care not covered under the named insurance policy.</p> |
| <p>_____</p> | <p>Trinity Lutheran Church has permission to use any photographs and/or video images of named minor for purposes of but not limited to promotional materials, website, and church newsletters. If you prefer your child NOT be photographed, please check here <input type="checkbox"/>.</p> |
| <p>_____</p> | <p>I understand it is my responsibility to notify the Beacon After School Program if my child will be absent or of other changes in attendance.</p> |
| <p><i>Patient/Guardian Signature Date</i></p> | |

TRANSPORTATION PERMISSION FORM

I, _____, give my permission for _____
(Printed Name of Parent) (Printed Name of Child)
to be transported from _____ to Trinity Lutheran Church,
(School)
508 Center Street, Ashland, Ohio 44805, by a Trinity Lutheran Church Van on full school days only for the 2024-2025 school year. This program is not available on snow days and early release days.

(Parent Signature)

(Date)

RELEASE OF INFORMATION

For Students Attending
Trinity Lutheran Church
Beacon After-School Program

I, _____, give my permission to the teachers and staff of
(Printed Name of Parent)
_____ School to share information relevant to the behavior
(Printed Name of School)
and/or academic concerns about my child, _____,
(Printed Name of Child)
with the staff at the Beacon After School program.

(Parent Signature)

(Date)