



**BRYTE AFTER SCHOOL PROGRAM**  
(Building Resourceful Youth Through Engagement)  
Located at the Millerton Elementary School, 2<sup>nd</sup> Floor

**2008-09 REGISTRATION FORM**

Child's Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Gender: M F Age: \_\_\_\_\_

Home Address: \_\_\_\_\_ Mailing address (if different): \_\_\_\_\_

Email Address: \_\_\_\_\_ Home Phone \_\_\_\_\_

Ethnicity (circle all that apply): African-American Caucasian Asian/Pacific Islander  
Hispanic Native American Other \_\_\_\_\_

**Parent/Guardian Information:**

Mother's Name	_____	Father's Name	_____
Day Time Phone	_____	Day Time Phone	_____
Cell Phone	_____	Cell Phone	_____
Employer	_____	Employer	_____
Email Address	_____	Email Address	_____
Address (if different from child)	_____	Address (if different from child)	_____

**If the child lives with someone other than their natural parents, please include contact information for the individual(s) with whom the child currently resides:**

Guardian Name	_____	Guardian Name	_____
Day Time Phone	_____	Day Time Phone	_____
Cell Phone	_____	Cell Phone	_____
Employer	_____	Employer	_____
Email Address	_____	Email Address	_____

**Emergency Contact Information:** (Name of someone besides yourself and/or spouse that may be contacted in the event of an emergency):

Name	_____	First Phone #	_____	Second Phone #	_____
Name	_____	First Phone #	_____	Second Phone #	_____

**Academic Information:**

Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

Academic Strengths & Needs: \_\_\_\_\_

Favorite Sports and activities: \_\_\_\_\_

Do you want us to ensure completion of homework? Yes No

Child's Name \_\_\_\_\_

Indicate below the times you anticipate your child to attend. We require two weeks' notice to change the schedule, and will charge for any day your child is registered and does not attend, unless we have 24 hours notice.

Day	Monday	Tuesday	Wednesday	Thursday	Friday

Are you interested in before-school care? If so, what time would you need it? \_\_\_\_\_

(We will add this option if there is sufficient interest)

What is your primary reason for registering with *BRYTE*?

Tutoring    Recreation    Mentoring    Child Care    Other \_\_\_\_\_

***Is there anything else you would like us to know about your child?*** (i.e. special needs, fears, talents, anything that will help us care for your child, etc.)

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***Transportation:***

All children take the designated bus from their school to the Millerton Elementary School. (Amenia Elementary School students will need to transfer at Webutuck Elementary School.) The transportation department requires a note stating that your child has permission to take these buses. Please complete the following section and we will provide it to the school transportation department.

I, \_\_\_\_\_, give permission for my child, \_\_\_\_\_,

who is in grade \_\_\_\_\_ at the \_\_\_\_\_ School to take the

designated bus to the Millerton Elementary School for the BRYTE After School Program. My child

will take the bus on:

**Monday   Tuesday   Wednesday   Thursday   Friday**

If there are any additional questions, please contact me at \_\_\_\_\_.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Child's Name: \_\_\_\_\_

What time will your child(ren) be picked up from the program (Millerton Elementary School, 5833 S. Elm Street)?  
\_\_\_\_\_

**Deposit, Fees and Payment**

A deposit equal to the amount of one week's tuition is due with the registration. Payment is due on the Friday before the following week. Payment can be made weekly or monthly, and can be mailed to NECC directly or given to the staff at the program. (See attached rate sheet.)

**PERMISSIONS**

Indicate your permission for each category.

***Permission to Consume Food:***

Each day, we provide a nutritious snack. Occasionally, an activity such as cooking will include additional food.

I **DO / DO NOT** give permission for my child to eat food provided by the BRYTE After School program.

**My child has the following food/drink allergy:**  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

***Permission to apply sunscreen:***

I **DO / DO NOT** give permission for the BRYTE After School staff to apply sunscreen to my child when needed.

***Permission to Transport:***

On occasion, there may be the need to transport your child (field trips, special projects, etc.). All transportation is provided by licensed staff and insured vehicles.

I **DO / DO NOT** give permission to BRYTE's staff to provide transportation as needed for my child.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Child's Name \_\_\_\_\_

**Permission to Pick Up:**

Your child will not be released to anyone not listed below. Until we are familiar with names and faces of authorized pick-ups, we will ask for your designated person to provide us with identification. **If there are custody issues that we need to be concerned with, please provide us with a copy of your court documents for our files** (all matters will be kept confidential).

The following person/people are authorized to pick up my child:

- 1. \_\_\_\_\_ Relationship: \_\_\_\_\_
- 2. \_\_\_\_\_ Relationship: \_\_\_\_\_
- 3. \_\_\_\_\_ Relationship: \_\_\_\_\_
- 4. \_\_\_\_\_ Relationship: \_\_\_\_\_

I **DO / DO NOT** give my child permission to walk home from the Millerton Elementary School.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Permission for Child's Name/Photograph to be released to the Press:**

Occasionally, BRYTE staff and press organizations, such as The Millerton News, will do stories and/or take pictures of program participants. These stories/photographs benefit both the program and the participants by building community awareness and instilling pride in the participants and may be used in NECC publications, websites, annual reports and other documents. Indicate your *Press Release* preference below.

I **DO / DO NOT** give permission for my child to have their name and/or photo released to the press.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Permission to obtain CACFP documentation from school:**

The BRYTE program participates in the Child & Adult Care Food Program through the New York State Department of Health. If you have completed an income verification form through the Webutuck School District, we can use those documents for this after school program. If you have not completed these documents, they are included in this application packet and are **required regardless of income** since reimbursement is granted for all income levels (all information is kept confidential).

I **DO / DO NOT** give my child(ren)'s school, \_\_\_\_\_, permission to provide the BRYTE After School program with a copy of my CACFP Income Eligibility documents for the 2007-08 school year.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Child's Name: \_\_\_\_\_

**Other Policies:**

Attached in the Program Policies and Procedures booklet is information about the following topics. Please read these sections and indicate below your acceptance.

**Well Child Policy:** I have read and understood the North East Community Center's "Well Child Policy". I understand that if my child exhibits any of the symptoms listed while in care, I will be called to pick up my child immediately and the child will not be able to return until the specified conditions are met.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Confidentiality and release of information:** I **DO / DO NOT** give the BRYTE after-school directors permission to communicate with my child's guidance counselor or teacher.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Ground rules and discipline policy:** I understand that breaking NECC's program ground rules may result in disciplinary action including written and verbal warnings, parental contact, suspension and expulsion from the program.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Child's Name \_\_\_\_\_

## PERSONAL HEALTH & MEDICAL RECORDS

A copy of your child's up-to-date immunizations MUST be provided before enrollment can be completed.

**IDENTIFICATION** - To be filled out by parent or guardian. Please print in ink.

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Name or Parent or Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If person above is not available in the event of an emergency, notify

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name of personal physician \_\_\_\_\_ Phone \_\_\_\_\_

Personal Health/Accident Insurance Carrier \_\_\_\_\_ Policy No. \_\_\_\_\_

I give permission for full participation in the BRYTE After School Program, subject to limitations noted herein. In case of emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission for BRYTE to contact the appropriate medical and/or dental practitioner. I also give permission to the licensed health-care practitioner selected by the staff member in charge to secure proper treatment, including hospitalization, anesthesia, surgery, and/or injections of medication for my child.

Date \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_

**GENERAL INFORMATION** - Check all items that apply, past or present, to your child's health history. Explain "YES" answers on a separate sheet of paper.

ADHD/ADD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer/Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions/seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

List any medications (including asthma inhalers/epi-pens) scheduled to be taken during program  
\_\_\_\_\_ When? \_\_\_\_\_

List any physical or medical conditions (**including allergies and their manifestation**) that may affect or limit full participation in our program:  
\_\_\_\_\_  
\_\_\_\_\_

List equipment needed such as braces, glasses, contact lenses, etc.  
\_\_\_\_\_  
\_\_\_\_\_

**IMMUNIZATION** (Give date of last inoculation- a copy of current immunization record **MUST be attached.**)

Tetanus toxiod \_\_\_\_\_ Mumps \_\_\_\_\_ Measles \_\_\_\_\_

Diphtheria \_\_\_\_\_ Rubella \_\_\_\_\_ Hepatitis B \_\_\_\_\_

Pertussis \_\_\_\_\_ Polio \_\_\_\_\_ Varicella \_\_\_\_\_

Haemophilus influenza type b \_\_\_\_\_