



**2019-2020 TRZ KIDZ PROGRAMMING
REGISTRATION FORM**
(One child per form/ new form each year)

The Relief Zone Inc.
5 Frew Run St. Box 334
Frewsburg, NY 14738
716-569-2614
trz@thereliefzone.org
www.thereliefzone.org

Name of Child: _____
Grade: _____ Age: _____ Date of Birth: / / _____

Gender: _____ Male _____ Female
Teacher: _____

Family Mailing Address: _____
_____ Zip: _____

Ethnicity (Please check those that apply): _____ Native American
_____ Caucasian _____ African American/Black _____ Asian
_____ Hispanic/Latino _____ Prefer not to answer

Parent or Guardian: _____
Relationship to child: _____
Home Phone: _____
Cell Phone: _____
Employer: _____
Work phone: _____
Email Address: _____
Does this person reside with the child? YES NO

Parent or Guardian: _____
Relationship to child: _____
Home Phone: _____
Cell Phone: _____
Employer: _____
Work Phone: _____
Email Address: _____
Does this person reside with the child? YES NO

Authorized Person for Pick Up/Emergency
Name: _____
Address: _____

Relationship _____
Phone #s: _____

Name: _____
Address: _____

Relationship _____
Phone #s: _____

Name: _____
Address: _____

Relationship _____
Phone #s: _____

PROGRAMS ATTENDING: (please mark in bubbles which programs your child will attend)

***Jumpstart Program**

(Please circle those that apply)

MONDAYS, TUESDAYS, WEDNESDAYS, THURSDAYS, FRIDAYS, ONLY WITH NOTE

MY CHILD WILL BE ATTENDING THE BREAKFAST PROGRAM EACH DAY

*** Afterschool Program**

(Please circle those that apply)

MONDAYS, TUESDAYS, WEDNESDAYS, THURSDAYS, FRIDAYS, ONLY WITH NOTE

***Half Dayz Program**

*** Full Dayz**

Payments are due at the beginning of each week and can be made by check, cash, paypal, and Venmo. (www.thereliefzone.org)

***Tutoring Program**

{afternoon only, one on one help and skill building, 30 minute sessions. Students are pulled out one at a time or in small group}

Any Classifications (i.e. 504, IEP) _____

***Homework Time**

{a quiet time and place for homework and/or studying to get done. Return to "normal" activities when they are done}

Would you like us to check folder and/or agenda in order to get Homework done (yes/no) _____

(If you sign up for tutoring or homework time, the tutoring coordinator will contact you to set up a plan for your child)

I give The Relief Zone and RHJ Staff permission to share information regarding my child, so that the staff may better understand any needs my child may have.

Signature _____

DATE _____

Important – This Box Must Be Completed For TRZ Program Attendance

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed program activities except as noted.

Publicity photos may be taken throughout the program duration. I allow my child to be included in photos.

Report card data and NWEA-MAP scores results are needed for program data collection; names of individual students are not disclosed, but needed for TRZ to apply for funding. I allow my child's data to be collected.

Authorization for Treatment:

I give my child permission to attend TRZ Kidz Programming. I understand the program rules. I also understand that on No School Dayz, Half Dayz and Summer Day Camp Dayz, the children may be walking to RHJ playground/nature trail, The Town Park playground/nature trail, Frewsburg Lanes, The Igloo, Frewsburg Fire Department, Frewsburger, Myers Library, or other local establishments. I give my child permission to go swimming off-site. (FCS Pool) I hereby give permission to staff to assist in the application of sunscreen to my child.

By signature below, I hereby release TRZ from all responsibility and liability for any injury or illness my child may sustain. In the event of a medical emergency, I give an adult leader of this program consent to any medical treatment my child may require.

I give permission to the medical personnel selected by the director to order X-Rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the director to secure and administer treatment, including hospitalization, for the person named above.

The completed forms may be photocopied.

Signature of Parent or Guardian _____

Date _____

| Please Complete the following questions. Be sure to provide an explanation where needed. | | | |
|------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|---------|--------|
| 1. | Is your child physically, mentally, and behaviorally able to participate in TRZ's School Age Child Care Program? | YES | NO |
| | If NO, please explain? | | |
| 2. | Does your child have any condition requiring special attention? | YES | NO |
| | If YES, please explain? | | |
| 3. | Does your child have an Individual Education Plan (IEP) or is being evaluated for one? (If YES, provide a copy of IEP) | YES | NO |
| 4. | Has your child had an illness/injury within the last year or an on-going condition which we should be aware of? | YES | NO |
| | If YES, please explain? | | |
| 5. | Is your child allergic to bee stings? (If YES, Medication Consent is needed) | UNKNOWN | YES NO |
| 6. | Is your child allergic to any food? | YES | NO |
| | If YES, Please Explain? | | |
| 7. | Is your child allergic to any medications? | YES | NO |
| | If YES, Please Explain? | | |
| 8. | Does your child have any other allergies (i.e. seasonal, etc.) ? | YES | NO |
| | If YES, Please Explain? | | |
| 9. | Does your child have asthma? (If YES, Medication Consent is Needed) | YES | NO |
| 10. | Is your child on any medication? | YES | NO |
| | If YES, Please Explain? | | |
| 11. | Does your child have any eye problems and/or wears glasses/contacts? | YES | NO |
| | If YES, Please Explain? | | |
| 12. | Does your child have any hearing problem? | YES | NO |
| | If YES, Please explain? | | |
| 13. | Does your child have any speech problems? | YES | NO |
| | If YES, Please explain? | | |
| 11. | Special needs or "triggers" we might need to know to help with your child's success: | | |
| | | | |
| 12. | Will your child be participating in the school breakfast program? | YES | NO |

Family Physician: _____ Phone: _____

Insurance Carrier: _____ Policy #: _____

(Office Use only) _____ Health Form _____ Registration Form _____ Registration Fee Paid