2019- STAR PROGRAM 2020 APPLICATION FORM

Dear Parents and Applicant:
Thank you for your interest in the STAR Program. Please fill out this application form completely.

The registration deadline is Wednesday, January 8, 2020. Your child will not be registered until all forms are completed. By signing this form, you accept the STAR Program Policies.

Applicant Name: , ,

(Last Name) **(First Name)** **(Middle Initial)**

Male ☐
Female ☐

DOB:

Race

Are you Hispanic or Latino?
Yes ☐
No ☐

What is your race? (Select one or more responses.)
☐ American Indian or Alaska Native ☐ Asian
☐ Black or African American ☐ White
☐ Native Hawaiian or Other Pacific Islander

Grade

What grade is your child in?

A. ☐ 6th grade
B. ☐ 7th grade
C. ☐ 8th grade
D. ☐ Ungraded or other grade

Parent/ Guardian-Contact Information

Parent/ Guardian #1

First:	Last:	Ms., Mrs., Mr., Other:
Street Address:		
Town/City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:
FAX:	Email:	
Occupation:	Employer:	

Parent/ Guardian #2

First:	Last:	Ms., Mrs., Mr., Other:
Street Address:		
Town/City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:
FAX:	Email:	
Occupation:	Employer:	

Emergency Contact Information/ Alternate Pickup/Release

Please list in order of preference individuals we may contact in the event of an emergency.

Name: **Relation to Child:**

Address:

Telephone:

Name: **Relation to Child:**

Address: **Telephone:**

Please list those people in addition to parents/guardians who are permitted to pick up your child:

1:

2:

3:

Medical Release Information

Insurance Information

Primary Insurance: **Policy Number:**

Primary Physician:

Address:

Phone: **Hospital Preference:**

Health and Participation Questions

1. Please list any medical problems, including and requiring maintenance medication (i.e. Diabetic, Asthma, Seizures.)

Medical Condition	Required Treatment	Should paramedic be called?

2. Does Your child require a special diet?
   Yes ☐ No ☐ **If yes, explain:**

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

3. How would you rate your child's ability to swim?

☐ **Strong Swimmer** ☐ **Moderate Swimmer** ☐ **Non-Swimmer**

4. Is your child involved in any extracurricular activities? If so, please list them below.

5. During the past 7 days was your child physically active for a total of at least 60 minutes per day? (Add up all the time your child spent in any kind of physical activity that increased their heart rate and them breathe hard some of the time.)

   A. ☐ 0 days E. ☐ 4 days
   B. ☐ 1 day. F. ☐ 5 days
   C. ☐ 2 days G. ☐ 6 days
   D. ☐ 3 days H. ☐ 7 days

Demographic Information- The YES Program relies on federal funding sources that require the following information. All information is confidential.

Household Income: ☐Below $15,000 ☐$25,000-$34,999 ☐ $45,000-$54,999
☐$15,000-$24,999 ☐$35,000-$44,999 ☐$55,000+

Release & Assumption of Risk: Participant specifically assume all risk of injury arising out of his/her presence on the premises of the YES program, my use of equipment and/ or facilities and my participation in activities, whether on its premises or at another location, and for myself and my heirs hereby waive, release and agree to hold free from all claims for damages the YES program and its offices, directors, or employees. I understand the risks and dangers involved in participating in such programs and agree not to participate in any activity that may injure myself or others. My signature also indicates my permission to use any other media for promotional and documentation purposes. (Note that parent or guardian must sign if participant is less than 18 years of age.)

Signature of Parent or Guardian Date

*Transportation Release

My child will need transportation home provided through the school district transportation department. Yes ☐ No ☐ Parent's/ Guardian's Initials

The YES Program Staff and its co-organizers are not responsible for lost or damaged personal property. All scheduled events are subject to change.

Printed Name of Parent /Guardian:

Parent/Guardian Signature: **Date:**

Physician's Statement of Health and Wellness

Name:

DOB:

Statement of Health to be completed by Physician

I have examined the individual named above and to the best of my knowledge; he/she is in good physical and mental health, free of any communicable diseases and is able to function in his/her full capacity. By signing below I certify that the above information is true.

Name (printed):

Signature:

Office Phone Number:

Office Address: Office Stamp (if available)