



# Gillam– Grant Community Center Before & After School Program

2025-2026 Registration

Participant Name: \_\_\_\_\_

Address: \_\_\_\_\_

Current Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Please Check One:  Boy  Girl

Before School

After School

Both

Full Time

Part Time (Please circle days needed): M T W TH F

Anticipated Drop Off Time (before school) \_\_\_\_\_

Anticipated Pick Up Time (after school) \_\_\_\_\_

## Parents/Guardians:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

## Emergency Contacts (other than above):

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

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



ADDITIONAL INFORMATION YOU WOULD LIKE US TO HAVE:

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**MEDICAL INFORMATION**

Check if applicable and give approximate dates:

History of:	Allergies:	Diseases:
____ Ear Infections:	____ Hay Fever:	____ Chicken Pox:
____ Rheumatic Fever:	____ Ivy Poisoning:	____ Measles:
____ Convulsions:	____ Insect Stings:	____ German Measles:
____ Diabetes:	____ Penicillin:	____ Mumps:
____ Behavior:	____ Other Drugs/FOODS:	____ Asthma:
____ ADD/ADHD:	____ Other:	____ Other:

Operations or serious injuries: \_\_\_\_\_

Chronic or recurring illness: \_\_\_\_\_

Other Diseases or details: \_\_\_\_\_

Any activity restrictions: \_\_\_\_\_

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**PHYSICIAN INFORMATION**

Physician Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_

Insurance Policy Name \_\_\_\_\_ Policy # \_\_\_\_\_

Initial

**PARENT/GUARDIAN AUTHORIZATION:** This registration and health history is true to the best of my knowledge, and the person herein described has permission to engage in all prescribed center activities, except as noted by me. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Gillam-Grant Community Center, to secure proper treatment for, and to order injections, anesthesia or surgery for my child as named on the registration form.

**Release:** I/We the parent(s) or guardian(s) of the child named on the reverse side of this form, who is enrolling in the Kid Zone After School Program, give my approval for his/her participation in activities related to this program. I/We do further, hereby release, indemnify, and hold harmless the Gillam-Grant Community Center, the instructors, teachers, and the Byron-Bergen Central School District. In case of injury, all claims will be hereby waived against the above mentioned.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# PARENT HANDBOOK 2025-26 SIGNATURE PAGE

PLEASE RETURN THIS PAGE WITH KID ZONE REGISTRATION FORM. THANK YOU!

I have read the attached **Parent and Student Handbook**. I understand the rules, payment expectations and policies.

Student Name: \_\_\_\_\_

Parent Name (printed): \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

## GENERAL PICTURE/VIDEO RELEASE

I, \_\_\_\_\_, myself or parent/guardian of the minor child listed above, do give permission for our picture and/or video participating in Gillam-Grant Community Center (GGCC) activities be used to display, promote and publicize GGCC. I confirm that I have the right to give permission for myself or my child without restriction or commitment to other parties, and that GGCC has no financial commitment or obligation to me or my child as a result of this agreement, I expressly release and indemnify GGCC from any and all claims known and unknown arising out of or in any way connected to the above-granted uses and representations. I have read the foregoing and understand and agree to the terms and stipulations as shown above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## DISMISSAL PERMISSION LIST

Please list all individuals who have your permission to pick up your child in your absence. Please notify these individuals that they will be required to provide photo identification to the Gillam Grant staff. Phone permission to release to anyone not on this list will only be allowed in extreme situations.

<u>NAME(S):</u>	<u>PHONE NUMBER(S)</u>	<u>RELATIONSHIP TO CHILD</u>
1.		
2.		
3.		
4.		
5.		
6.		