ADAMS 12 FIVE STAR SCHOOLS STEM IGNITION 2018 PERMISSION FORM

ALL AREAS MUST BE FILLED IN. IF NOT APPLICABLE, WRITE N/A.

STUDENT INFORMATION	
Name:	Birthdate: _____ Grade: _____ (Circle) M/F
Address:	City, Zip Code:
PARENT/GUARDIAN INFORMATION	
Name:	Name:
Relationship to Student:	Relationship to Student:
Address:	Address:
City, Zip Code:	City, Zip Code:
Home Phone:	Home Phone:
Employer:	Employer:
Address:	Address:
City, Zip Code:	City, Zip Code:
Work Phone:	Work Phone:
Cell Phone:	Cell Phone:
Email:	Email:
Emergency Contact Information (Persons other than parent, to be notified in an emergency):	
Name:	Name:
Relationship to Student:	Relationship to Student:
Address:	Address:
City, Zip Code:	City, Zip Code:
Phone:	Phone:
Alternative Phone:	Alternative Phone:
Pick Up Authorization (Names of persons, other than parent, to whom student may be released):	
Name:	Name:
Relationship to Student:	Relationship to Student:
Phone:	Phone:
Prohibited Authorization (Names of persons, NOT authorized to pick up the student):	
Name:	Name:
Relationship to Student:	Relationship to Student:
Phone:	Phone:

PLEASE INITIAL <u>ONE</u> OF THE OPTIONS AND SIGN BELOW.

_____ I AUTHORIZE MY CHILD TO CHECK HIM OR HERSELF OUT AND WALK HOME FROM STEM IGNITION.

_____ I WILL PICK HIM/HER UP OUTSIDE AT 3:30 AT THE CLOSE OF STEM IGNITION. I REALIZE THERE IS NO SUPERVISION AFTER 3:30

PARENT SIGNATURE: _____ **DATE:**_____

CONSENT FOR EMERGENCY MEDICAL CARE AND SHARING OF INFORMATION

I, the undersigned, a parent or guardian of the above named student herein authorizes all adult sponsors, or any responsible adult person bearing this written authorization into whose care the above mentioned minor has been entrusted, to consent to any x-ray examination, anesthetic, medical, surgical diagnosis or treatment and hospital care. Such care is to be rendered to said minor under the general or special supervision and upon the advice of a physician, dentist, and/or surgeon licensed to practice in the State Of Colorado and to consent to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care. In addition, I authorize all school and District staff to exchange relevant information about my student. It is understood that this authorization is given for all program- sponsored activities. Every effort will be taken to locate a parent/guardian before any action is taken. All medical expenses will be accepted by the parent/guardian. STEM Ignition is absolved of any or all liability for accidents or injuries received during any or all program-sponsored activities.

_____ _____

Authorized Signature Date

_____ _____

Student Name Grade

ADAMS 12 FIVE STAR SCHOOLS
ADULT AND STUDENT CODE OF CONDUCT AGREEMENT

Every person that enters Northglenn STEM is a potential role model for the students present. As role models we are ALL expected to portray citizenship, kindness/respect for all, positive communication, problem solving behaviors, and appropriate regard of school property.

Per State law, smoking, drug and/or alcohol use are never permitted. If suspected abuse occurs, the person(s) involved will be subject to removal from district grounds.

All district and Superintendent policies apply to STEM Ignition.

While every effort will be made to resolve a conflict, we reserve the right to immediately terminate care should a parent/guardian or custodial dispute affect the program, personnel, or students in a threatening manner. Please refer to the Discipline Procedures and policies within district and school handbooks.

I understand and agree to adhere to the "Code of Conduct Agreement."

_____ _____

Parent/Guardian Signature Date

_____ _____

Student Signature Date

Late or Unexpected Closures or Emergency Situations

The supervising staff at STEM Ignition will attempt to text parents or guardians who complete the following cell phone contact section for information on closures or emergency situations. Please be aware that normal texting or cell phone charges may apply depending on your service provider and/or coverage area.

_____I would like to be contacted via a text message on my cell phone if STEM Ignition closes early, unexpectedly, or there is an emergency situation that I need to be made aware. I understand that I may be charged a fee from my cell phone service provider. I also understand this procedure will only be used for unexpected closures or emergency situations.

Full Name: _____

Cell Number: _____ Service Provider: _____

STEM Ignition
Late Pick up Agreement

STEM Ignition ends at 3:30 p.m. We encourage parents or guardians to try to contact family members or neighbors on the authorized pick up list if they know they will be late picking their student up. If students are not picked up on time, students will lose the opportunity to attend future sessions.

I understand and agree to adhere to the "Late Pick up Agreement" for Northglenn HS STEM Ignition program.

_____ _____
Student's Name Grade

_____ _____
Parent/Guardian Signature Date

Students T- Shirt Size
(Adult)

[ ] Small [ ] Medium [ ] Large [ ] X-Large [ ] XX-Large

Adams12 Five Star Schools

Medical Emergency Form

I / We, _____, being the parent/legal guardian of _____, give my consent for emergency medical and surgical treatment in a licensed hospital by a licensed physician, should his/her condition require treatment in my absence. I / We understand that, in such case, reasonable attempts will be made to contact me/us, time and conditions permitting.

As long as the medical or surgical treatment considered necessary in the situation is in accordance with generally accepted standards of medical practice for the particular type of injury or illness involved, I/we impose no specific prohibitions regarding treatment unless stated here (if none, so state):

My daughter/son has the following medical condition(s) which may require emergency care:

The District and its personnel cannot dispense medication without written direction from the child's (student's) physician stating the child's name, the name of the medication, the dosage and the period for which the medication is prescribed.

My daughter/son requires the following medication(s):

The authorization is for the time period beginning **June 4, 2018** and ending **June 8, 2018.**

_____ _____

Signature of Parent or Guardian Date