

Part I EPNC Teen Registration Form: September 2018-August 2019



Participant's Name (First, Middle, Last) _____

Male / Female _____ Birthdate _____ Age _____

Grade in Fall 2018 _____ School Attending in Fall 2018 _____

Elver Park Neighborhood Center
Program Site _____

Mother / Father / Guardian (**Circle one.**) Primary Account Holder _____

Mother / Father / Guardian (**Circle one.**) Secondary Contact Person _____

Address _____

Address _____

City/State/Zip _____ Home Phone _____

City/State/Zip _____ Home Phone _____

Work Phone _____ Cell Phone _____ Best Phone # During Program Hours _____

Work Phone _____ Cell Phone _____ Best Phone # During Program Hours _____

E-mail Address _____

E-mail Address _____

Participant resides with: Mother(s) Father(s) Guardian(s) Other Relationship: _____

Participant previously attended the 2017-2018 center program: Yes No

Special Health Information (Please be specific; use other side if necessary.)

Allergies: _____ Have Epi Pen: Yes No

Medical Conditions: _____

Behavioral/Emotional Needs: _____

Asthma: _____ Have Inhaler: Yes No

Emergency Contact/Pick-up Authorization Information:

In addition to primary and secondary persons listed above, list one emergency contact (REQUIRED). In an emergency, if no contact can be made to those listed here, the police department may be notified. Add additional authorized pick up persons here, if applicable.

Name (First & Last)	Best Phone # During Program Hours	Complete Home Address	Relationship to Child	Emergency Contact Person
				<input checked="" type="checkbox"/>
				<input type="checkbox"/>

Registration Agreement

- I am aware that if my child's participation in any Elver Park Neighborhood Center program(s) for which he/she is registered requires more than reasonable accommodations, whether due to special needs or behavior, my child may be removed from the program.
- I understand if my child has any special needs, I have so indicated in the special health information section of this form.
- In the event my child becomes ill or injured, I understand that an effort will be made to reach me or an emergency contact person on file. I give consent for the Elver Park Neighborhood Center to act on my behalf to obtain emergency care and treatment if deemed necessary.
- I am aware that my child may have the opportunity to participate in field trips. I give consent for my child to participate in field trips and be transported to and from any scheduled program activity for which transportation is required.
- I understand my child is eligible for the shuttle provided by Elver Park Neighborhood Center and give my permission for my child to ride the shuttle. I am also aware this shuttle is a privilege and my child will not be allowed to ride the shuttle if my child exhibits unacceptable behavior.
- I understand that WYC may contact me via text messaging for the purpose of communicating urgent information that involves my child's program. I understand that I can opt-out of this service by contacting the WYC administrative office.
- I give permission for my child or me to appear in any media coverage approved by Wisconsin Youth Company Inc. (WYC) and for WYC to use photos of my child in WYC publications, flyers, website and social media.
- My child and I have read and understand the Elver Park Neighborhood Center Code of Conduct, and my child has agreed to follow these rules and understands that he/she may be suspended or removed as a participant if he/she violates any of the rules.

Name of Mother / Father / Guardian (Please Print) _____

Name of Participant (Please Print) _____

Signature of Mother / Father / Guardian (**Circle one**) _____ Date _____

Signature of Participant _____ Date _____

Office Use Only - Date Received _____ Intake Initials _____ WAIT LIST: M T W R F Date Confirmed _____

Demographic Information (collected for grant reporting purposes only):



1. My child's ethnicity is:

- Also Hispanic or Latino
- Only Hispanic or Latino
- Not Hispanic or Latino

2. My child's race is (check all that apply)

- White/Caucasian
- Black/African American
- Asian
- American Indian/Alaska Native
- Native Hawaiian or other Pacific Islander
- Black/African American and White/Caucasian
- Asian and White Caucasian
- American Indian/Alaska Native and White/Caucasian
- American Indian/Alaska Native and Black/African American
- Other: _____
(please specify)

3. There are _____ members of my household with a disability.

4. The head of my household is male female

5. There are _____ number of people in my household.

6. The annual income of my household is approximately _____.



This program is funded through a grant from the City of Madison.



Participant Code of Conduct Agreement 2018-2019

The Elver Park Neighborhood Center is sponsored and hosted by Wisconsin Youth Company, Inc. The center is dedicated to providing safe, healthy, meaningful and fun programs for our community. Each organization offering a program has the same set of expectations.

Rule #1 Safety First

Check-In. When you arrive at the center **check into the center by signing in on the attendance sheet.**

This building is to be a safe place for all participants and staff.

No drugs, alcohol, cigarettes, weapons or any illegal materials are allowed on the property.

No gang activity of any kind including language and hand gestures is permitted.

All participants and staff must be free from harm. Harming anyone or threatening anyone is not permitted. Fighting and illegal activities are not permitted on the property. Incidents will be reported to parents and authorities; suspensions and expulsions may result.

Rule #2 Be Respectful

In order to provide healthy, meaningful and fun programs every person must be respectful of every person.

- Swearing and disrespectful comments will not be tolerated.
- Rudeness, hand and face signs or comments meant to hurt anyone are not allowed.
- Bullying or taking advantage of anyone is not permitted.

Any participant who violates the rules (our code of conduct) is subject to discipline, up to and including removal from the program and the center.

Rule #3 Be Responsible

In order to provide healthy, meaningful and fun programs every person must be responsible for their own behavior.

All rules must be followed. Program directions by adult leaders must be respected. Listening to others is important for a fun and safe experience. There are many times you will need to understand and accept other people's needs. They are expected to do the same for you.

Damage, theft or destruction of anything that does not belong to you will result in charges for repair or replacement.

The Elver Park Neighborhood Center and Wisconsin Youth Company, Inc. reserve the right to prosecute offenders to the fullest extent of the law.

I have read and I understand the Elver Park Neighborhood Center's Code of Conduct. I agree to follow these rules and understand that I may be removed as a participant if I violate any of these rules.



Participant's Signature: _____ **Date:** _____



Parent/Guardian Signature: _____ **Date:** _____

**Middleton-Cross Plains Area School District
PERMISSION TO OBTAIN AND RELEASE INFORMATION**

Student:	Street Address:	Date of Request:
Date of Birth:	City, State, Zip Code:	Person Authorized to Consent:

	Authorizes	To Obtain from and Release info to:
Name of Provider	Wisconsin Youth Company	Middleton-Cross Plains Area School District
Street Address	1201 McKenna Blvd.	7106 South Avenue
City, State, Zip	Madison, WI 53719	Middleton, WI 53562
Phone #	608-276-9782	
Fax #		(608) 836-1536
Email		

This disclosure is being made for the following purpose(s):

- | | |
|--|--|
| <input type="checkbox"/> Qualification for Individualized Education Plan | <input type="checkbox"/> At the Request of an Individual |
| <input type="checkbox"/> School Related Health Information | <input checked="" type="checkbox"/> Other <u>Ongoing communication</u> |
| <input type="checkbox"/> Further Medical Information Needs | |

Information to be Released:

- | | |
|---|---|
| <input checked="" type="checkbox"/> Behavioral Records | <input type="checkbox"/> Social Work Report |
| <input type="checkbox"/> Social Work Report | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> IEP Team Evaluations & Related Reports | <input type="checkbox"/> Operative/Procedure Report |
| <input type="checkbox"/> Appropriate Agency Reports | <input type="checkbox"/> Immunizations |
| <input checked="" type="checkbox"/> Progress Notes | <input type="checkbox"/> EKG/EMG/EEG |
| <input type="checkbox"/> Info. Necessary for Cont. Care | <input type="checkbox"/> PT/SP/OT |
| <input checked="" type="checkbox"/> Other <u>Academic</u> | <input type="checkbox"/> Labs |
| <input type="checkbox"/> Law Enforcement Records | |

In compliance with Wisconsin and Minnesota Statutes that require special permission to release otherwise privileged information, please release records pertaining to:

- | | |
|--|---|
| <input type="checkbox"/> Mental Health & Psychological Reports & Testing | <input type="checkbox"/> HIV(AIDS) Records |
| <input type="checkbox"/> Phone Consultation | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Drug Abuse or Test Results | <input type="checkbox"/> Other |

REDISCLASURE NOTICE – HIV Test Results – I understand that the HIV test results of pupils may be released without authorization to persons/organization that have access under Wisconsin law and a list of those persons/organizations is available upon request.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

RIGHT TO INSPECT OR COPY THE HEALTH INFORMATION TO BE USED OR DISCLOSED – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form, along with a right to receive a copy of this authorization form. This authorization is voluntary. Refusal to sign will not affect health care treatment, payment for health care, health care plan enrollment or benefits except for: No Exceptions Exceptions (specify): _____

REDISCLASURE NOTICE – The information that I authorize to be released may be redisclosed by the recipient of the records only if allowed by law. If information is redisclosed, the recipient of the redisclosed information may be controlled by different laws. I recognize that these records, once received by the school district, may not be protected by the Health Insurance Portability and Accountability Act (HIPPA) and may become education records protected by the Family Educational Rights and Privacy Act (FERPA) with additional protection afforded by Wisconsin Statutes 118.25 (2m)(a)(b) and 146.82 – 146.83.

RIGHT TO REVOKE – I may revoke this authorization, in writing, at any time except for information already released as a result of this authorization. The written revocation must be given to the agency/organization I authorized to release information.

EXPIRATION DATE – This authorization is valid for one year from the date signed. A copy of this form is as effective as the original. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

As evidenced by my signature, I hereby authorize disclosure of records to the person(s) or agency(s) specified above.		
SIGNATURE – Student (14 years of age or older)		Date Signed
SIGNATURE – Other Person Legally Authorized to Consent to Disclosure	Title or Relationship to Individual who is the Student	Date Signed