OFFICE USE ONLY:	Date Received	Enrollment #

Wampanoag Tribe of Gay Head (Aquinnah) Education Department

2023-2024 After-School Program Registration Packet

This is a registration packet for a Tribal child to attend the WTGH(A) After-School Program, also referred to as ASP. The After-School Program will begin **Monday, September 11** and will run Monday–Friday, 2:40PM–5:30PM, with pick-up time ending at 6:00PM. The last day of the program will be Friday, June 14, 2024. Please ensure that your child meets the following requirements before registering:

- ☐ is a registered Tribal member of the Aquinnah Wampanoag Tribe
- ☐ is enrolled in Grades K-6 for the school year
- ☐ will be 5 years of age by the end of the 2022
- ☐ is capable of using the bathroom themselves (potty-trained)

Note that the Registration Packet contains multiple forms, *all of which are required*. Please submit the forms and any accompanying documents to the Education Department. You may refer to this checklist and ensure you have all the documents:

- ☐ After-School Program General Registration Form, *p. 2-3*
- ☐ Emergency Contact and Dismissal/Release Form, *p. 4*
- ☐ Transportation Permission/Release of Liability Form, *p. 5*
- ☐ Photo/Video & Social Media Release Form, *p. 5*
- ☐ Permission to Administer First Aid/Emergency Services Form, *p. 6*
- ☐ ASP Medical Form, *p. 7-8*
- ☐ Immunization Record **OR** Refusal to Vaccinate Form, *p. 9*

Once you have completed this packet, please submit it and the accompanying documents to the Education Department. **This program will have rolling enrollment; there is no "deadline," however registering after the program starts may result in your child not having the materials needed for certain activities.** Please reach out to staff if this is a concern.

By email:	Email this file to Jade at eduspec@wampanoagtribe-nsn.gov	By Mail:	20 Black Brook Rd Aquinnah, MA 02535 ATTN: Jade Maak	In-person:	Please call or text: 508-560-1894 OR 508-645-9265 x154

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After-School Program General Registration Form

PART A. STUDENT INFORMATION

Child's Full Name____

Child's Preferred Name/Nickname____________________________ Gender____________________

Tribal Enrollment Number______________ Age_______________ Date of Birth_____/_____/__________

Enrolled School____ Grade____________

PART B. FAMILY INFORMATION

1st Parent/Guardian's Full Name________________________________ Relation to Child_______________

Daytime Phone #__________________________ Can this number receive text messages? ☐ YES ☐ NO

Evening Phone #__________________________ Can this number receive text messages? ☐ YES ☐ NO

Email____

Street Address____

____

Mailing Address____

____

2nd Parent/Guardian's Name_________________________________ Relation to Child_______________

Daytime Phone #________________________ Can this number receive text messages? ☐ YES ☐ NO

Evening Phone #________________________ Can this number receive text messages? ☐ YES ☐ NO

Email____

Street Address (if different)____

____

Mailing Address (if different)____

____

Child resides with: ☐ 1st Parent/Guardian ☐ 2nd Parent/Guardian ☐ Both ☐ Other:_______________

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Please list all siblings/household members that will also be enrolled in the program:

Name____ Relation to Child__________________________

Name____ Relation to Child__________________________

Name____ Relation to Child__________________________

Name____ Relation to Child__________________________

PART C. PROGRAM INFORMATION

Please select which days of the week your child will be attending ASP.

Note: Once enrolled, your child is entitled to come all 5 days. This is to inform staff of any recurring absences.

☐ **Mondays** ☐ **Tuesdays** ☐ **Wednesdays** ☐ **Thursdays** ☐ **Fridays**

Does your child have a current Individualized Education Plan (IEP)? ☐ YES ☐ NO

If yes, please submit a copy with this registration packet and it will be discussed personally with the Education Program Specialist. All information will be kept confidential.

Does your child have a current 504 Plan? ☐ YES ☐ NO

If yes, please submit a copy with this registration packet and it will be discussed personally with the Education Program Specialist. All information will be kept confidential.

Is there any other information about your child that you would like us to inform us about?

PART D. PARENT/GUARDIAN SIGNATURE

By signing this form and submitting it with the Registration Packet, I am registering my child for enrollment in the After-School Program for the 2023-2024 school year. I agree that all the information provided is true. I have read the *After-School Program Policies and Procedures* with my child and helped them to understand the program rules and expectations. In the event that any of the above information changes, I will inform the Education Department as soon as possible.

____ ____________________________

Parent/Guardian Signature *Date*

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Emergency Contact and Dismissal/Release Form

Child's Full Name: ____

Please fill in the names of persons *other than the parent/guardian(s)* that will serve as emergency contacts *and* have your permission to pick up your child from the After-School Program. Individuals NOT listed below will not be able to pick up your child from our program.

____

Name *Relationship* *Phone*

____

Name *Relationship* *Phone*

____

Name *Relationship* *Phone*

____

Name *Relationship* *Phone*

____

Name *Relationship* *Phone*

Does your child have permission to walk or bike home BY THEMSELVES at the end of After-School Program (5:30pm)?

☐ YES ☐ NO

Is there anyone who is NOT permitted to pick up your child from our program?

If yes, the Education Department will reach out to discuss this matter. Any special instructions such as custody or restraining orders must be attached to this registration packet. All information will be kept confidential.

☐ YES ☐ NO

________________________________ ________________________

Parent/Guardian Signature *Date*

You are entitled to change this list at any time. Changes must be made IN WRITING to be in effect.

Please inform Education Department staff if you would like to make changes or resubmit this form.

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Transportation Permission/Release of Liability Form

I, the undersigned parent/guardian, understand and **AGREE** to allow my child to be transported by the Wampanoag Tribe of Gay Head (Aquinnah) to various locations on Martha's Vineyard for activities involved with the After-School Program. These locations include but are not limited to public beaches, libraries, public playgrounds, and areas on Tribal lands. The Education Department staff will inform me of these trips via text.

I agree that the transportation of my child by the WTGH(A) will be at my own risk. I expressly, voluntarily, and knowingly release, agree to protect, hold harmless and indemnify the WTGH(A), its employees, representatives, officers, advisors, agents, members, and any and all individuals or organizations affiliated with the WTGH(A) from any liability, loss, damage, costs, claims, and/or causes of action, including but not limited to all bodily injuries, property damage, property loss, and/or theft of any property arising out of transportation of my child by the WTGH(A).

By signing below, I verify that I have read the above Release of Liability and have voluntarily signed with full understanding of its purpose.

____ ____

Parent/Guardian Name (Print) *Child's Name*

____ ____

Parent/Guardian Signature *Date*

Photo/Video Release Form

I, the undersigned adult parent/guardian, **AGREE** to allow photos and/or videos taken of my child during the After-School Program to be used for the Wampanoag Tribe of Gay Head (Aquinnah) Education Department for their website, brochures, flyers, calendars and any other use deemed appropriate for the department's use, including publishing in the Toad Rock Times. The pictures and/or videos will not be used by other organizations without my written consent.

____ ____

Parent/Guardian Name (Printed) *Child's Name*

____ ____

Parent/Guardian Signature *Date*

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Permission to Administer First Aid, Emergency Services

In the event of an emergency, injury or situation that requires medical attention, I request that the After-School Program staff make every effort to contact me and the listed emergency contacts. However, I/WE, the undersigned adult(s), authorize the After-School Program staff to obtain whatever medical attention is appropriate including the use of emergency medical technicians reached through 911 services for ______________________________________.

Child's name

Do you have medical insurance for this child? ☐ Yes ☐ No

If YES, please fill out the following:

Insurance Company: ____

Policy Subscriber's Full Name: ____

Policy #____

____ _________________________

Parent/Guardian Signature *Date*

____

Parent/Guardian Signature

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After-School Program Medical Form

Child's Name:____ Birth Date: _______________ Sex: _______ Age:______

Pediatrician or Physician:____________________________________ Phone:__________________________________

Date of last physical examination: ____________________________

Dentist or Orthodontist:_____________________________________ Phone:______________________________

Health History: (Give approximate dates)

Conditions:	Allergies:	Diseases:	Other (Please specify):
☐ Frequent ear infections	☐ Asthma	☐ Mononucleosis	
☐ Heart defect/disease	☐ Hay fever	☐ Chicken pox	
☐ Convulsions	☐ Poison ivy	☐ Measles	
☐ Diabetes	☐ Insect sting	☐ German measles	
☐ Bleeding/Clotting disorder	☐ Penicillin	☐ Mumps	
☐ Chronic Lyme disease	☐ Alpha-GAL Syndrome (AGS)		

Other chronic conditions or diseases:____

Dietary Modifications (including allergies):____

Does your child use any of the following? ☐ Eyeglasses ☐ Contact lenses ☐ Hearing aid

List any medications taken by your child and reason for taking:

Medication:____ Reason:_________________________________

Medication:____ Reason:_________________________________

Medication:____ Reason:_________________________________

I authorize my child to apply topical medications such as ☐ SUNSCREEN, ☐ ALOE VERA, ☐ CALAMINE LOTION, and ☐ BUG/TICK REPELLENT under the supervision of the After-School Program staff.

*Please initial here:*_____________

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Comments or Details of Above:

____

____

____

____

____

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.

______________________________________ ______________________________________

Parent/Guardian Name (Printed) *Child's Name*

______________________________________ ______________________________________

Parent/Guardian Signature *Date*

EMERGENCY AUTHORIZATION: I hereby **GIVE PERMISSION** to medical personnel at the nearest urgent care to order x-rays, routine tests and treatment for my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician to hospitalize, secure proper treatment for, and to order injections of anesthesia and/or surgery for my child as named above.

____ _______________________________

Parent / Guardian Signature *Date*

Name of Minor: ____

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Immunization Record

(to be completed by child's physician)

Required immunization must be determined locally. Please record the date (MM/YY) of basic immunizations and most recent booster doses:

VACCINES	Date of Basic Immunization	Date of Last Booster
Diphtheria		
Pertussis (Whooping Cough)		
Tetanus		
DPT or		
Tetanus TD		
Diphtheria or		
Tetanus		
Oral Polio (Sabin) TOPV Injectable Polio (Salk) Measles (hard measles, red measles, Rubella)		
Mumps		
Rubella (German Measles or 3-day Measles)		
Most recent Tuberculin test given (TINE)		
Other (specify):		

____ _____________________________

Physician Signature *Date*

Or please attach a form with immunization records from your physician's office with the signature of the physician.

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or Refusal to Vaccinate

I have decided at this time to decline or defer the vaccines recommended for my child. I know I may readdress this issue with my child's doctor or nurse at any time and that I may change my mind and accept vaccination for my child any time in the future. I acknowledge that by signing here I have agreed to tell all health care professionals in all settings what vaccines my child has not received because he or she may need to be isolated or may require immediate medical evaluation and tests that might not be necessary if my child had been vaccinated in the event of a medical emergency.

____ ____

Child's full name *Parent/Guardian Signature*

____

Date