



Wampanoag Tribe of Gay Head (Aquinnah) Education Department

2022-2023 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 12** and will run Monday–Friday, 2:40PM–5:30PM, with pick-up time ending at 6:00PM. 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
- Emergency Contact and Dismissal/Release Form
- Transportation Permission/Release of Liability Form
- Photo/Video & Social Media Release Form
- Permission to Administer First Aid/Emergency Services Form
- ASP Illness Medical Form
- ASP Emergency Procedure Card
- Immunization Record
- OR** Refusal to Vaccinate Form

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

After-School Program General Registration Form

PART A. STUDENT INFORMATION

Child's Full Name: _____
 Child's Preferred Name/Nickname: _____
 Gender _____ 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 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 (if different) _____
 Mailing Address (if different) _____

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

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 2022-2023 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. I have also reviewed and agree to abide by the *COVID-19 Protocol*. In the event that any of the above information changes, I will inform the Education Department as soon as possible.

Parent/Guardian Signature

Date

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

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.

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 (Print)

Child's Name

Parent/Guardian Signature

Date

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

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:

- Frequent ear infections
- Heart defect/disease
- Convulsions
- Diabetes
- Bleeding/Clotting disorder
- Chronic Lyme disease

Allergies:

- Asthma
- Hay fever
- Poison ivy
- Insect sting
- Penicillin
- Alpha-GAL Syndrome (AGS)

Diseases:

- Mononucleosis
- Chicken pox
- Measles
- German measles
- Mumps

Other (Please specify):

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: _____

OFFICE USE ONLY: Date Received	Enrollment #
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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: _____

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.

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