Navigators Afterschool Enrollment Form

Jennifer Holland, Navigators Afterschool Program Director ♦ jsholland@tdarschool.org

Attendance Dates and Payments

Please check the programming you wish your child(ren) to participate in.

☐ Navigators Afterschool Program – Elementary Students Only

The Navigator's Afterschool Program follows the calendar for the School District of Oconee County and operates from 3 pm to 6 pm on all regular school days.

☐ Full Days – Elementary Students Only

The Navigator's Afterschool Program is open for full days during breaks and Teacher In-Service days. Indicate if your child will be attending fall, winter, and/or spring break. The deadline to notify the Navigator Afterschool Director of your child attendance is two weeks prior to the full day.

☐ Fall Break (Oct. 7-11) ☐Winter Break (Dec. 23-Jan 3) ☐ Spring Break (Mar. 17-21)

☐ STEM Club - K-7th Grade

BRIEF Navigators STEM Club begins September 19, 2024.

Fees are due at time of enrollment for all Non-Afterschool Participants.

☐ All Sessions $145 ☐ Fall Semester $90 (9/17-12/5/2024) ☐ Spring Semester $105 (1/16-5/1/2025)

Payment Agreement

To be enrolled in any of the programs above, a SmartCare Account must be created for your family and a working debit/credit card kept on file for payment on the account. Payment will be processed on the 28th of each month. **If you want to cancel enrollment, you MUST cancel in writing by 2:30 p, on the 25th of the month.** This will ensure that the Navigators Director will have time to remove the charge from your account before it is automatically processed. If your card is declined when automatically processed, you will be contacted that same day and asked to provide an alternative card to be placed on your SmartCare account and charged that business day. **If you are not able to pay for the upcoming month, your child's registration will be removed.** Please remember that we have a scholarship application available upon request for families in need. **Please be advised that NO refunds will be given once a charge is processed through SmartCare.**

_____ _____

Parent/Guardian Name Parent/Guardian Signature

Student Name(s):_____

Student and Health Information – First Child

Child's Name: _____ Birthdate: _____
Grade: _____ School: _____

Academic Information

Has your child ever been tested for special needs? ☐ YES ☐ NO
Does your child have a 504 plan or Individualized Education Plan (IEP)? ☐ YES ☐ NO
What goals or expectations do you have for your child during their time in the program?

_____

What areas of concern, regarding their grades or academics do you have?

_____

Medical Information

Allergies/Dietary Concerns: _____
Diagnosed Special Needs: _____

_____

Physical Limitations / Other Medical Concerns: _____

_____

Family Physician: _____ Phone #: _____
Address: _____
Family Dentist: _____ Phone #: _____
Address: _____
Health Insurance Provider: _____
Certificate of Immunization: ☐ YES ☐NO ☐N/A, please explain: _

Emergency Contacts

List individuals approved to make emergency medical decisions regarding this child.
(Individuals must be 18 years or older.)
Emergency Contact 1: _____ Phone: _____
Emergency Contact 2: _____ Phone: _____
Emergency Contact 3: _____ Phone: _____

_____ _____
Parent/Guardian Signature Date

Student and Health Information – Second Child

All information must be completed for each child.

Child's Name: _____ Birthdate: _____
Grade: _____ School: _____

Academic Information
Has your child ever been tested for special needs? ☐ YES ☐ NO
Does your child have a 504 plan or Individualized Education Plan (IEP)? ☐ YES ☐ NO
What goals or expectations do you have for your child during their time in the program?

_____

What areas of concern, regarding their grades or academics do you have?

_____

Medical Information
Allergies/Dietary Concerns: _____
Diagnosed Special Needs: _____

_____

Physical Limitations / Other Medical Concerns: _____

_____

Family Physician: _____ Phone #: _____
Address: _____
Family Dentist: _____ Phone #: _____
Address: _____
Health Insurance Provider: _____
Certificate of Immunization: ☐ YES ☐NO ☐N/A, please explain:

Emergency Contacts
List individuals approved to make emergency medical decisions regarding this child.
(Individuals must be 18 years or older.)
Emergency Contact 1: _____ Phone: _____
Emergency Contact 2: _____ Phone: _____
Emergency Contact 3: _____ Phone: _____

_____ _____
Parent/Guardian Signature Date

Student and Health Information – Third Child

All information must be completed for each child.

Child's Name: _____ Birthdate: _____
Grade: _____ School: _____

Academic Information
Has your child ever been tested for special needs? ☐ YES ☐ NO
Does your child have a 504 plan or Individualized Education Plan (IEP)? ☐ YES ☐ NO
What goals or expectations do you have for your child during their time in the program?

_____

What areas of concern, regarding their grades or academics do you have?

_____

Medical Information
Allergies/Dietary Concerns: _____
Diagnosed Special Needs: _____

_____

Physical Limitations / Other Medical Concerns: _____

_____

Family Physician: _____ Phone #: _____
Address: _____
Family Dentist: _____ Phone #: _____
Address: _____
Health Insurance Provider: _____
Certificate of Immunization: ☐ YES ☐NO ☐N/A, please explain: _

Emergency Contacts
List individuals approved to make emergency medical decisions regarding this child.
(Individuals must be 18 years or older.)
Emergency Contact 1: _____ Phone: _____
Emergency Contact 2: _____ Phone: _____
Emergency Contact 3: _____ Phone: _____

_____ _____
Parent/Guardian Signature Date

Medication Administration

Child's Name: _____ Reason for Medication: _____

Possible Side Effects:

_____

Contact Details of Prescribing Physician:
Physician's Name: _____ Physician's Phone: _____

Directions for Dosage: _____

Is this medication self-administered by the child? ☐ YES ☐ NO

I, _____, give permission to authorized staff member(s) to administer medication to my child as indicated below.

_____ _____
Parent/Guardian Signature Date

Medication Details

Allergies: _____

Medication Name: _____

Dosage: _____

Directions: _____

Amount: _____

Refills (amount/date/initials): _____

_____ _____
Doctor's Signature Date

Family Information

Home Address

_____

_____

Father's Information

Father/Guardian Name: _____

Cell Phone: _____ Work Phone: _____

Email: _____ Other Phone: _____

Mother's Information

Mother/Guardian Name: _____

Cell Phone: _____ Work Phone: _____

Email: _____ Other Phone: _____

Demographic Information

All demographic information will be kept private and only used for internal purposes and for collated reporting to funders.

How did you hear about our program? _____

Household Size:
Members of the Household over the age of 18 years old: _____.
Members of the household 18 years of age and below: _____.

Income Level: Please check the income level that is most appropriate.

☐ $0 - $20,000 ☐ $20,000 - $30,000 ☐ $30,000 - $40,000
☐ $40,000 - $50,000 ☐ $50,000 - $60,000 ☐ $60,000 +

Does your family quality for Free/Reduced Lunch? ☐ YES ☐ NO

Race/ Ethnicity: Please check **ALL** that apply.

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic, Latino, or Spanish
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other

Education Level: Please check the highest level of education for each parent / guardian.

Father/Guardian 1	Mother/Guardian 2
☐ Some High School	☐ Some High School
☐ High School Graduate	☐ High School Graduate
☐ Some College	☐ Some College
☐ Associate's Degree/Certification	☐ Associate's Degree/Certification
☐ Bachelor's Degree	☐ Bachelor's Degree
☐ Master's Degree or Higher	☐ Master's Degree or Higher

Additional Adults Approved for Pick Up

Authorized Pickup 1: _____ Phone #: _____

Authorized Pickup 2: _____ Phone #: _____

Authorized Pickup 3: _____ Phone #: _____

Authorized Pickup 4: _____ Phone #: _____

Adults NOT Approved for Pick Up

Name 1: _____

Name 2: _____

Name 3: _____

Consent to Receive or Disclose Information

The information will be disclosed to and used by the Navigators Afterschool Program at Tamassee DAR School, P.O Box 8, Tamassee, SC 29686.

Purpose of Request: Educational Needs

I understand that information about my child(ren) may be received/disclosed with the following school and teaching staff:

Child 1: _____

Teachers(s)/School: _____

Child 2: _____

Teachers(s)/School: _____

Child 3: _____

Teachers(s)/School: _____

___ **Initials:** I understand this consent may be used to provide two-way communication (received & disclosed) between the above listed school and Tamassee DAR School for the development and academic needs of the child named above.

___ **Initials:** I understand that I have the right to revoke this consent at any time by providing a written statement to the Navigators Afterschool Program Director at Tamassee DAR School, except to the extent that action has already been taken based on this consent and with the knowledge that it could inhibit my child's care.

___ **Initials:** I understand that I may obtain any information used or disclosed.

___ **Initials:** I understand that refusal or withdrawal of this consent may inhibit the academic needs of my child.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Navigators Afterschool Director Date

Authorization to Transport

We are pleased to have the opportunity to transport your child to the Navigators Afterschool Program. Students are expected to engage in appropriate behavior at all times while riding in a Tamassee vehicle. **If your child is absent from school or is not attending Afterschool on any day, it's the parent/guardian's responsibly to notify the Navigators Afterschool Director and the child's school.**

During transportation, your child(ren) will be expected to meet the following expectations.

- Stay seated and seatbelt always fastened.
- Use a quiet voice.
- Keep hands and feet to self (not in aisles or on others).
- Follow all directions of the driver.

Failure to maintain these rules may result in a loss of transportation privileges.

Child's Name_____ Date of Birth _____
School:_____

Child's Name_____ Date of Birth _____
School:_____

Child's Name_____ Date of Birth _____
School:_____

I hereby give permission to Tamassee DAR School to transport my child(ren) to the Navigators Afterschool Program. My signature below indicates that I have read and agree to the transportation rules.

_____ _____
Print Parent/Guardian Name Date

_____ _____
Signature of Parent/Guadian Date

Release of Liability

In consideration of allowing the previously declared participant(s) to begin participation in the Summer Camp Program at Tamassee DAR School, while on the premises and property of the School, the undersigned, for themselves, and/or being the legal and acting guardian of participant(s), acting for themselves and on behalf of the participant(s), release and hold harmless Tamassee DAR School, its employees and volunteers from any and all liability, claims, demands, and causes of action whatsoever, arising out of or related to any loss, damage, or injury, including death, that may be sustained by the participant, while in or upon the premises upon which the Summer Camp Program is conducted, or any premises under the control and supervision of Tamassee DAR School employees and volunteers, in route to or from any of the said premises, or while at any premises or place when activities sponsored by or participated in by Tamassee DAR School employees and volunteers.

_____ _____

Signature of Parent/Guadian Date

Release for Publicity

☐ I do give my consent for Tamassee DAR School to use my child's name, image, photograph, or other identifying information in written or visual form for the school's newsletter or other media. I realize that many of the school's activities include groups of children, and I do not wish for my child to be excluded from photographs that are used as recognition of accomplishments or as information only.

Tamassee DAR School is completely committed to rejecting any use of children's names, photographs, or other identification in any manner whatsoever that could be considered exploitation. No child will ever be intentionally used in such a manner.

Tamassee DAR School will teach all children the basic principles of good citizenship, the ability to care for themselves, and the ability to relate to others. Best judgment will be used in all matters of publicity pertaining to my child.

☐ I do NOT give my consent for Tamassee DAR School to use my child's name, image, photograph, or other identifying information in written or visual form.

_____ _____

Signature of Parent/Guadian Date

Field Trips: Parent Chaperones

Only complete if you want to serve as a Volunteer Parent Chaperone.

The Navigator Afterschool Program attends several field trips throughout the year. Volunteer Parent Chaperones are essential to keep our students together and safe. A clear background check is required for all volunteers each year, including Parent Chaperones. If you want to serve as Volunteer Parent Chaperone for field trips, please complete the Consent to Release Information on the following page.

Reset

South Carolina Department of Social Services

CONSENT TO RELEASE INFORMATION

With my signature below, I consent for the South Carolina Department of Social Services to conduct a one-time search of the records indicated below to determine whether they contain information that I was the perpetrator of harm to a child and to release information found to the individual/organization named below.

I understand that the information provided may prove to be unfavorable to me. I agree to hold the South Carolina Department of Social Services and its staff harmless from liability associated with release of information requested on this form. If it appears to me that the information has not been updated or is otherwise inaccurate, I agree to notify the Department immediately.

SECTION I. Purpose for Request

A. I am requesting a search of the Central Registry of Child Abuse and Neglect and the Department's database of records of Child Abuse and Neglect cases in connection with:

- ☐ becoming or remaining a foster parent or potential adoptive parent; or
- ☐ becoming or remaining an employee of or a member of the state or a local foster care review board; or
- ☐ becoming an employee or volunteer for the South Carolina Guardian ad Litem Program or Richland County CASA.

B. ☑ I am requesting a search **ONLY** of the Central Registry of Child Abuse and Neglect for a purpose of VOLUNTEER.

SECTION II. Mail Results To:

TAMASSEE DAR SCHOOL
P.O. BOX 8
TAMASSEE, SC 29686

ATTN: JAN HONEYCUTT
TEL. NO: 864-944-1390 EXT 104

SECTION III. Central Registry Check Fees: Please ☑ appropriate box and include payment. Check or Money Order (NO CASH).

- ☑ Non-Profit Entities.....$8.00
- ☐ For-Profit Entities.....$25.00
- ☐ State Agencies.....$8.00
- ☐ Schools.....$8.00
- ☐ Name Changes.....$8.00
- ☐ Other (Individuals, etc.).....$8.00
- ☐ Private Adoption Investigations.....$25.00

SECTION IV. Please print legibly or type the following: First, Middle and Last Name (NO INITIALS)

Name: _____ DOB: _____ Sex: _____ Race: _____

Maiden/Aliases: _____ Name Change: _____

Place of Birth: _____ SSN: (See instructions) _____

Current Address: _____ Previous Address: (See instructions) _____

SECTION V. Your signature MUST be witnessed or notarized. Please mail appropriate payment and form for processing to: South Carolina Dept. of Social Services, **ATTN: Cashier,** 1535 Confederate Avenue, P.O. Box 1520, Columbia, SC 29202-1520.

_____ _____
Signature of Applicant Date

_____ _____
Signature of Notary or Witness Date

SECTION VI. RESULTS: THIS SECTION IS TO BE COMPLETED ONLY BY AUTHORIZED DSS EMPLOYEES OF THE DEPARTMENT.

- ☐ The name is not included as a perpetrator on the Central Registry of Child Abuse and Neglect.
- ☐ The request has been received. Additional research will be required to respond to the request. Thirty to sixty days may be required. Please call _____ if you have any questions.
- ☐ The name is included as a perpetrator on the Central Registry of Child Abuse and Neglect.
- ☐ The name is included as a perpetrator in the Department's database of records of child abuse and neglect cases. See attached correspondence.

_____ _____
Authorized DSS Employee Date

YogaFaith Consent

Tamassee DAR School offers Christian yoga throughout the school year. This form provides consent and release for your student to participate.

Child 1: _____
Yoga Experience Level: ☐Beginner ☐Intermediate ☐ Advanced
Do you have any medical restrictions or conditions? ☐ YES ☐ NO If yes, please explain:
_____

Child 2: _____
Yoga Experience Level: ☐Beginner ☐Intermediate ☐ Advanced
Do you have any medical restrictions or conditions? ☐ YES ☐ NO If yes, please explain:
_____

Child 3: _____
Yoga Experience Level: ☐Beginner ☐Intermediate ☐ Advanced
Do you have any medical restrictions or conditions? ☐ YES ☐ NO If yes, please explain:
_____

YogaFaith Disclaimer (Please check each box.)

☐ I hereby consent as a participant in YogaFaith classes and agree to assume all of the risks involved. I release YogaFaith from any known or unknown injury, accident, or hazard, previously, during, or after participation in a YogaFaith class a11d/or training or related activities; and that I cannot hold YogaFaith, affiliated YogaFaith teachers, or location host, personally responsible for any liability.

☐ I recognize that any form of physical activity has potential risk of injury. I hereby affirm that I am voluntarily participating in a YogaFaith activity with the knowledge of the risk involved. I assume and accept any and all risks of injury and hazards.

☐ I hereby affirm myself to be in physical condition to practice in YogaFaith with no medical condition or injury preventing me from participating. I declare that I have disclosed any and all medical issues to YogaFaith and/or their affiliates relevant to participation or have been cleared by a physician to participate in class and/or training.

_____ _____

Signature of Parent/Guadian Date

Blue Ridge Innovation Entrepreneurship Foundation

PHOTO CONSENT FORM

I, _____ (parent/guardian) with a mailing address of _____in the city of _____, in the state of_____ (zip code)_____ grant permission and give my consent to Blue Ridge Innovation & Entrepreneurship Foundation (BRIEF) to photograph _____ (student name(s) and post on social media for the purpose of sharing information about BRIEF and promoting BRIEF programs to supporters, partners and followers.

Signature Required:

Parent/Guardian _____

BRIEF representative_____

National Society Daughters of the American Revolution

PHOTO/VIDEO RELEASE FORM

I, *(please print full name neatly)* _____,
hereby grant permission to the National Society Daughters of the American Revolution (NSDAR), including any of its chapters or state societies, to publish photos/images/videos including the name of my child in press releases and/or other materials either in print or electronic format for purposes deemed appropriate by the NSDAR.

I am signing this release form with the knowledge that any photos/images/videos posted electronically and in press releases can be downloaded and reprinted by news organizations, individuals and others including print, electronic, and broadcast media, and I, therefore, release the NSDAR from any liability arising from use of my child's photos/images/videos in web postings.

I further understand that if I wish to rescind this agreement, I may do so at any time by sending a letter to NSDAR. I further understand that already published photos/images/videos cannot be recalled. The requested rescission will take effect upon receipt of the notification.

Name of minor child: _____
(PRINT NAME)

Signature: _____ Date: _____

NSDAR CONTACT INFORMATION

Name of Contact: Mrs. Debbie Lamb Junior American Citizens Club Sponsor

Phone No. (864) 710-3924 E-mail _____