HIGHLAND LOCAL SCHOOLS DISTRICT’S
HIGHLAND EXPRESS AFTER SCHOOL CHILD CARE PROGRAM

STUDENT ENROLLMENT INFORMATION

Bus number ________

Child’s Name ____________________________ Date of Birth __________________

Child’s Teacher _________________________ Room No. ________ Grade ________

Home Phone Number ____________________ Cell Number(s) __________________

Names and ages of brothers and sisters ________________________________________

Who lives in the home with the child? (mom, dad, grandma, etc.) _________________

____________________________________________________________________________

Mother’s Name _____________________ Father’s Name ______________________

Parent’s Status: Married _____ Divorced _____ Single _____ Widow(er) _____

Previous school or child care center/provider _________________________________

Has your child experienced any changes lately? (moving, new baby, etc.) ________

____________________________________________________________________________

Is there anything you feel the child care staff should know about your child? ________

____________________________________________________________________________

Please list all of your child’s medications and/or allergies _______________________

____________________________________________________________________________

RELEASE OF CHILD

Name and relationship of ALL people authorized to take your child from the facility:

____________________________________________________________________________

____________________________________________________________________________

Is there anyone NOT allowed to take your child from the facility?

____________________________________________________________________________ Reason: ____________________________

LATCHKEY START DATE: ____________________________

____________________________________________________________________________

(Parent Signature) ____________________ (Date) ______________________

(Rev. May 2018)
PARENT AGREEMENT CONTRACT
THE HIGHLAND EXPRESS
GRANGER  HINCKLEY  SHARON
ELEMENTARY SCHOOLS

Child’s Name_________________________________ Grade ___________
Address ______________________________________________________
Home Phone Number ___________________________________________

Mother’s Name ________________________________________________
Work Phone # ____________________ Cell # _______________________
E-mail address_________________________________________________

Father’s Name _________________________________________________
Work Phone #____________________  Cell# ________________________
E-mail address _________________________________________________

DAYS OF ATTENDANCE:  (Please circle)
Monday  Tuesday  Wednesday  Thursday  Friday  As Needed

TIMES OF ATTENDANCE:  A.M.  P.M.  FULL TIME  AS NEEDED
(Please circle the above)

Please sign and return this contract:
I agree to pay the applicable fees associated with my child’s participation in the program. All fees are expected to be paid in full by the end of each month. Unpaid balances may result in your child being excluded from attending the Latchkey Program. Fees may be paid online or by check. We appreciate your cooperation and look forward to your child’s participation.

_______________________________________   _______________________________
Parent’s Signature     Date

*PLEASE REMEMBER: IF SCHOOL IS DELAYED, LATCHKEY WILL BE CLOSED. ALSO, IF SCHOOL IS DISMISSED EARLY, LATCHKEY WILL BE CLOSED. IF YOUR CHILD IS ABSENT FROM SCHOOL, HE/SHE MAY NOT USE THE PROGRAM THAT DAY. *
LATCHKEY EMERGENCY DISMISSAL FORM

Please complete this form and return to school. Make sure you fill this form out carefully. If an emergency evacuation or weather dismissal occurs, the media will be alerted as quickly as possible, you will receive a telephone call through our parent alert system, our website will be updated, and you will receive an e-mail if you are signed up through our Highland website at www.highlandschools.org to receive e-newsletters and other important school information. The telephone lines need to be kept open for emergencies. All children will be released using the directions chosen on this form.

The following directions have been given to my child:

Name ____________________________________________________________

Grade _________________ Teacher __________________________________________

_________ My child is to go directly home. Bus # ______

_________ My child is to ride his/her regular bus and get off at a neighbor’s home.

Neighbor’s Name ____________________________________________

Address _______________________________________________________

Neighbor’s Phone _______________________________________________

_________ My child is to be transported by a different bus to the following address in our elementary busing area:

Name _________________________________________________________

Address _______________________________________________________

Bus Number #_______

It is imperative that your child is informed to what he/she is to do in such emergencies as well as having this information on file. The school CANNOT make phone calls.

I have discussed the emergency procedures with my child and he/she knows what to do and where he/she will go if school is dismissed early due to an emergency.

__________________________________________  _______________________
Parent Signature                        Date

(Rev. 5/2018)
HIGHLAND LOCAL SCHOOLS EMERGENCY MEDICAL AUTHORIZATION FORM
O.R.C. 3313.712

Purpose – To enable parents and guardians to authorize the provisions of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian Contact Information

<table>
<thead>
<tr>
<th>Name/Relationship:</th>
<th>Home Phone:</th>
<th>Work Phone:</th>
<th>Cell Phone:</th>
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<tbody>
<tr>
<td>Parent/Guardian:</td>
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<td>Parent/Guardian:</td>
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<td>Relative/Other:</td>
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PART I OR II MUST BE COMPLETED

Part I – To Grant Consent

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor: ___________________________ Phone: ___________________________

Dentist: ___________________________ Phone: ___________________________

Medical Specialist: ___________________________ Phone: ___________________________

Local Hospital: ___________________________ Emergency Room Phone: ___________________________

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child’s medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

___________________________________________________________________________________________________

___________________________________________________________________________________________________

Date: _____________________ Signature of Parent/Guardian: _____________________

Phone: ____________________ Address: ____________________

Part II – Refusal To Consent

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

___________________________________________________________________________________________________

___________________________________________________________________________________________________

Date: _____________________ Signature of Parent/Guardian: _____________________

Phone: ____________________ Address: ____________________