CRA Education Support Program
Registration Form

FORM A
SIDE 1

Please complete both sides

Please fill out all listed forms when registering:

____ FORM A – Registration – completed, Side 1 and Side 2

____ FORM B: Health Form – completed by child's physician For safety reasons, all health forms must be submitted to the CRA.
___ Doctor _____ is faxing form to CRA.

____ Payment NOTE: Payment for first week is due to reserve spot. Contact Jon Yetto with questions at jyetto@daltoncra.org.

Student Information (* required information)

Student's Name* _____

Date of Birth _____

Home Address* _____

Grade as of September 2020* _____ Gender M ___ F ___

Does student have allergies and/or a special diet* __Yes __ No

(if yes, describe) _____

Prescription Medications (doctor's note required)* __Yes __ No

_____

Parent/Guardian Information

Parent/Guardian Name* _____

Mailing Address* _____

Relationship to Student _____

Phone Number 1* _____

Phone Number 2 _____

email* _____

Parent/Guardian Name _____

Home Address _____

Relationship to Student _____

Phone Number 1 _____

Phone Number 2 _____

email _____

Emergency Contact Information (other than Parents/Guardians)

Name _____

Phone Number _____

Name _____

Phone Number _____

Others Who May Pick Up Student (proof of I.D. may be requested upon pick-up)

Name _____

Relationship to Student _____

Phone Number _____

Name _____

Relationship to Student _____

Phone Number _____

General Release / Photo Release / CRA Education Support Program Policies and Procedures Release

- **General Release:** *I hereby acknowledge that participation in the Education Support Program carries with it a potential risk of harm. Accordingly, in consideration of my being permitted to participate in a CRA program, I hereby release the Community Recreation Association, Inc. (CRA), The CRA Board of Governors, The CRA Board of Trustees, the Central Berkshire Regional School District, the Town of Dalton, the instructors and employees of the foregoing from any and all claims or other liability for illness or injury to person or property arising out of participation in the Education Support Program.*

Parent's / Guardian's Signature _____ Date _____

- **Photo Release:** *I grant to the CRA, the right to take photographs of my child(ren) in connection with this program. I authorize the CRA, its assigns and transferees to copyright, use and publish the same in print and/or electronically. I agree that the CRA may use such photographs of my child(ren) with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content.*

Parent's / Guardian's Signature _____ Date _____

Your child's safety is the CRA's top priority. Due to the COVID-19 virus, we are taking extra precautions. We continue to review all policies and procedures and will make modifications to comply with state and local officials and medical expert's advice.

Community Recreation Association
400 Main Street • Dalton, MA 01226 • (413) 684-0260 • FAX: (413) 684-4033 • daltoncra.org

CRA Education Support Program
Registration Form

FORM A
SIDE 2

Please complete both sides

Student's Name _____

Grade as of September 2020 _____

School Attending and Cohort (Group A or B) _____

PAYMENT

Space is limited and student must be registered for all three weeks. Registration for the Education Support Program requires payment for the first week (four days) in the amount of $140 and will ensure your child's spot in the program. By signing up, your child is guaranteed a slot in the program and you must pay for the slot whether your child attends or not. The cost for the five days per week program is $175 and payment is due the Friday before. Non-payment will result in your child losing their spot in the program.

SCHEDULE		COST	AMOUNT
☐ Week 1	September 15 - 18, 7:30 am - 3 pm	$140/week	
☐ Week 2	September 21 - 25, 7:30 am - 3 pm	$175/week (due by 9/18)	
☐ Week 3	September 21 - 25, 7:30 am - 3 pm	$175/week (due by 9/25)	
☐ Cohort A	Tuesday and Friday (Remote Learning)	$70/week	
☐ Cohort B	Monday and Thursday (Remote Learning)	$70/week	
☐ Remote Learning	Wednesday	$35/week	
☐ Aftercare	Days Attending ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday	$15/day	

Please Note: Student must be enrolled in the Educational Support Program to attend Aftercare. There is no minimum number of days student can attend, however, you are reserving a spot and are responsible for payment whether or not student attends. **Example: If you sign up for Aftercare on Monday and Friday, you will be responsible to pay for both days each week for the remainder of the program.** A two-week notice is required to change or remove selected days.

Total Enclosed

Please fill out and return to:
CRA Education Support Program, 400 Main Street, Dalton, MA 01226
For questions please contact jvetto@daltoncra.org.

☐ **Check Enclosed:** Please make payable to **Dalton CRA**

☐ **Please charge my:** ☐ MasterCard ☐ Visa $_____

Card Number _____

Exp. Date ____ /____ Security Code _____

_____
Name as it appears on Card

The Community Recreation Association's Education Support Program is in full compliance with the Massachusetts Department of Public Health (MDPH) and is licensed by the LOCAL BOARD OF HEALTH.

FOR OFFICE USE ONLY
DATE REC'D _____
INITIALS _____

Education Support Program	$140	$175	$175
Aftercare			
___ Monday	$15		
___ Tuesday	$15		
___ Wednesday	$15		
___ Thursday	$15		
___ Friday	$15		
Total $_____			

Parent's / Guardian's Signature _____ Date _____

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HEALTH & RELEASE FORM

FORM B

(YOU WIL NOT BE ADMITTED WITHOUT THIS AND OTHER LISTED MEDICAL FORMS REQUIRES PHYSICIAN'S SIGNATURE.)

Program: _____ Program Location: _____ Program Dates: _____

Student/Staff Name: _____ Sex: _____ Age: _____ Height: _____ Weight: _____

Address: _____
Number and Street (and Apartment) *City* *State* *Zip Code*

Home Tel #: _____

Parent/Guardian: _____ Tel # (C): _____ Tel # (W): _____

Emergency Contact Name: _____ Tel # _____

Location if travelling during program: _____ Tel # _____

HEALTH HISTORY

Physical Restrictions: _____

_____

Medications: A separate Prescription Medication Record Form must be completed for each medication. _____

_____

Medical History a/o Medical Condition(s) which would require special attention: _____

_____

The program health staff may administer the following over-the-counter medications: ☐ Tylenol® or generic ☐ Advil® or generic ☐ Neither

The student or staff member may self-administer the following: ☐ Inhaler ☐ Epi-pen ☐ Neither

HEALTH INSURANCE

Carrier: _____ Policy Number: _____

Policy Holder: _____ Holder's DOB: _____

I hereby that the named program student/staff member is physically able to participate in the CRA Education Support Program and that I know of no restrictions, physical impairments, or any other condition, other than noted above, which would limit, in any manner, his or her participation in this program.

I hereby give permission for the program health staff to dispense the prescription medications listed above. I hereby give permission for the named program student/staff to receive emergency medical or surgical treatment and hospitalization if necessary. I understand that every attempt will be made to contact me, or the emergency contact named above, before taking this action. I UNDERSTAND THAT THERE IS A RISK OF INJURY TO THE NAMED PROGRAM MEMBER/STAFF AS A RESULT OF PROGRAM ACTIVITIES, AND KNOWINGLY AND VOLUNTARILY ASSUME ALL RISK OF SUCH INJURY. I will be financially responsible for any medical attention needed during the program or resulting from an injury received at the program. My medical insurance shall be the insurance coverage for any medical treatment.

_____ _____

Signature of Parent or Guardian (or staff member, if over 18) *Date Signed*

HEALTH RECORD

Immunizations	Dates Administered			
MMR Vaccine (1 MMR, 1 additional Measles)				
Measles				
Mumps				
Rubella				
Polio (3 doses)				
Diphtheria/Tetanus/Pertussis (4 doses)				
Hepatitis B (3 doses)				

Medical problems, restrictions, limitations, etc. _____

Physician's Name: _____ License # and State: _____

Address: _____

_____ _____

Physician's Signature *Date Signed*

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