

# 2017 – 2018 BLAST Program Registration

BLAST begins October 10, 2017



## Registration

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

**1<sup>st</sup>-2<sup>nd</sup> Grade** -  I want my child to participate on Tuesdays and Thursdays.

**3<sup>rd</sup>-5<sup>th</sup> Grade** -  I want my child to participate **on the following days each week:**

Monday       Tuesday       Wednesday       Thursday

*Please check all that apply. You may choose 1, 2, 3, or all 4 days.*

## Field Trip Permission

- I give permission for my student to participate in *all* BLAST field trips during the 2017-2018 school year (you will be notified of field trip dates at the beginning of each month or sooner).
  - All field trips will be back to Red Creek Elementary School by 5:30 each night.
- I would like to decline having my child participate in field trips.

## Parent/Guardian Information

Parent/Guardian Name \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_ *Best way to contact between 3:00 – 5:30* \_\_\_\_\_

## Emergency Contacts:

*In the event the parents/guardians cannot be reached, BLAST will call the people listed below. People listed should be individuals who can pick up your child if your child needs a ride home or becomes ill between 3:00 – 5:30pm.*

Name: _____	Name: _____
Home phone: _____	Home phone: _____
Work phone: _____	Work phone: _____
Cell phone: _____	Cell phone: _____
Relationship to student: _____	Relationship to student: _____

## Student Pick Up:

*Please list people who you authorize to pick up your child from BLAST.*

Name: _____	Name: _____
Phone: _____	Phone: _____
Relationship to student: _____	Relationship to student: _____

My child should walk/ride bike home from BLAST.

## Medical Information:

In case of a serious accident or illness and I cannot be reached, I hereby authorize Dr. \_\_\_\_\_ to render necessary treatment. Phone# \_\_\_\_\_

If the named doctor is not available, any physician may render treatment.

Health Conditions/Allergies: \_\_\_\_\_

## Photo Release

I grant the BLAST Program and any partners, the right to use, publish, and copyright my child's image (including audio, moving image, or photograph) for educational programs, website, and promotion of BLAST successes and events in local publications. BLAST and their community partners adhere to all Federal and State laws associated with this use. Please check one response:

Yes       No

SIGNATURE _____ DATE _____ PARENT / GUARDIAN
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