2024 SUMMER SCHOOL PROGRAM

*Application packet information must be filled out completely and accurately to ensure enrollment into summer programming. Incomplete applications will not be accepted.

Child's Name: ______________________________ Date of Birth: ______________

Child's Address:______________________________Male:________ Female:_______
(Must reside within KCPSD Boundaries)

City/State:___________________________Zip:____________ Home Phone:______________

Ethnicity: African American______Caucasian______Hispanic______ Asian _____ Native American ______ Other ______

Grade Entering in the **Fall 2024**:_________________ School Currently Attending:_________________

Mother's Name:_____________________________ Cell/Work Phone No.:______________

Father's Name:_____________________________ Cell/Work Phone No.: ______________

PARENT EMAIL:____

Does child have any food,medication or any types of allergies? Yes________ No________ If Yes, please explain:____

Is Child Taking Any Medication? Yes_______No_______If Yes, please explain:______________________
____

*All daily required medications/supplies must be provided to the summer school nurse before the first day of summer school. Students will not be permitted to stay without all medical supplies described above.

Emergency Contact Information:

Name:	Phone No.:	Relationship:
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

In the event my child (children) incurs bodily injury or some other form of serious illness and if the persons listed above cannot be contacted at the numbers listed above, and immediate first aid, medical or surgical treatment appears necessary regarding such injury or illness, then I hereby authorize management staff to act on my behalf, rendering first aid and/or arranging for my child's (children) transportation and admission to a hospital. I hereby authorize and hold harmless Guadalupe Centers, Guadalupe Educational System, and said representatives thereof, said hospital (and its employees or agents), and said physician from any claim or losses whatever arising out of the foregoing.

I have received, read, and agree to all information contained within the GC Summer School Program 2024 Parent Handbook.

Parent/Guardian Signature: Date:

_________________________________ ____________________

Summer School Site Location:

WESTSIDE - GC Middle School (Kinder -8th Grade -**EAST - GC Elementary School -** 5123 E Truman Rd Kansas City, MO 64127 (Kinder - 5th Grade)

TShirt Size: Youth: XS S M L XL **Adult:** XS S M L XL

Office Use Only
Checklist Complete:________
Date Approved:__________
Staff Initials:___________

2024 Summer School Program
Emergency Contact/
Authorization for Pick-up Form

✱All information provided below must be accurate and current✱

In the event of an emergency involving my child ____,
Child's Name

please contact the following persons in the order listed below:

Parent/Guardian Name: ____________________________ Relationship to child ______________________

Address: _____________________________________ City, State, Zip Code __________________________

Home Phone: (_______)_____________________ Work or other #: (_______)________________________

Name: ____ Relationship to child ______________________

Address: _____________________________________ City, State, Zip Code __________________________

Home Phone: (_______)_____________________ Work or other #: (_______)________________________

Name: ____ Relationship to child ______________________

Address: _____________________________________ City, State, Zip Code __________________________

Home Phone: (_______)_____________________ Work or other #: (_______)________________________

Name: ____ Relationship to child ______________________

Address: _____________________________________ City, State, Zip Code __________________________

Home Phone: (_______)_____________________ Work or other #: (_______)________________________

*I authorize the above mentioned individuals to pick up my child from the GC Summer School Program. Guadalupe Centers, its employees, and agents may rely on this authorization at all times.

Parent/guardian signature **Please Print Name**

____ ____

Note: Please include area code on all phone numbers.

Field Trip/Swimming Permission Slip

Parent/Guardian Permission Slip and Liability Waiver for Field Trip

I,__________________________________ request that my child, ________________________________,

Parent/Guardian Child's Name

participate in any and all field trips/class outings planned for the 2024 Guadalupe Centers Summer School Program.

I understand that as a parent/legal guardian, I remain legally responsible for any personal actions taken by the above named participant. I further agree that I will instruct my child regarding swimming and pool safety and direct my child to avoid horseplay or risky behavior that may harm my child or another person.

I agree on behalf of myself, my child named herein,our heirs, successors and assigns to hold harmless and defend the Guadalupe Centers, Guadalupe Educational System, its officers, employees, volunteers, chaperones, agents and representatives associated with these activities, its parent corporation, subsidiary, or affiliates, from any claim arising from or in connection with my child attending the activity or in connection with any illness or injury (including death) or cost of medical treatment resulting from the activity; and further, I agree to compensate the Guadalupe Centers, Guadalupe Educational System its officers, employees, volunteers, chaperones, agents and representatives associated with these activities for reasonable attorney's fees and expenses which may be incurred in any action brought against them as a result of such injury or damage, unless such claim arises from the actual negligence of theGuadalupe Centers or Guadalupe Educational System. To the best of my knowledge, my child is in good health and is physically able to participate in these activities. I assume all responsibility for the health of my child.

Signature:____Date:________________

Guadalupe Centers

2024 Summer School Program

Authorization to Dispense Medication

Date: ______________________

I, _____________________________________ authorize the site coordinator/school nurse
Parent/guardian name

of the Guadalupe Centers 2024 Summer School Program to dispense the following medication(s)

Please list name of medication(s):

1. ___________________________________ Time: __________________

2. ___________________________________ Time: __________________

as prescribed to my child ____
Child's Name

*Please briefly explain what the medication(s) is/are used for

____

____

____
Parent/guardian signature

____
Site Coordinator Signature

REMINDER:

***All medication must be in the original prescription bottle with your child's name or in the original packaging before it will be distributed.**

***All medication and supplies must be provided to the summer school program nurse before participants are allowed to stay at program sites.**

Photo Release Form

I hereby grant to Guadalupe Centers, Guadalupe Educational System ("GES") or entity in partnership with and its legal representatives and assigns, the irrevocable and unrestricted right to use and publish photographs of me, or in which I may be included, but am not identified by name, on the GES website or the Guadalupe Centers ("GC") web site, and in any publication of any media that publicizes or promotes the website as part of GES and or GC; and to alter the same without restriction, including the right to crop the photograph or not to use the photograph; and to copyright the same for GES or GC. I hereby release the photographer and his/her legal representatives and assigns from all claims and liability relating to said photographs. I hereby agree that any photo that is taken of me while I am a participant in any GES or GC activity is solely the property of either GES or GC.

If minor, name and signature of parent or guardian(18 or over):

Student Name: (print)____

Date:_________________________________

Parent/Guardian:____

Relationship to Minor:____

Signature:____

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE
CHILD AND ADULT CARE FOOD PROGRAM

MEDICAL FOOD SUBSTITUTION RECORD

The Child & Adult Care Food Program Requirements for Meal Pattern Substitutions Section 7.5 require food substitutions to be authorized by a recognized medical authority. Recognized medical authority includes physician, physician assistant, or nurse practitioner. The recognized medical authority must specify, in writing, the food to be omitted from the patient's diet and the food or choice of foods that may be substituted.

PATIENT'S NAME:

MEDICAL DIAGNOSIS / REASON:

SPECIAL ASSISTANCE/EQUIPMENT REQUIRED:

FOOD SUBSTITUTION LIST:

Fluid Milk	Allowed Substitutes	Texture (e.g., cut up, ground mince, puree, liquidity)
Meat & Meat Alternative (e.g., eggs, cheese peanut butter, dry bean, yogurt, etc.)	Allowed Substitutes	Texture (e.g., cut up, ground mince, puree, liquidity)
Bread, Cereal or Whole Grain Products	Allowed Substitutes	Texture (e.g., cut up, ground mince, puree, liquidity)
Fruit & Vegetables or Juice	Allowed Substitutes	Texture (e.g., cut up, ground mince, puree, liquidity)

Additional Dietary Concerns and/or Required Equipment or Assistance Needed:

I (medical authority) certify that the above patient must be provided a special diet or requires special accommodations as indicated above.

SIGNATURE	TITLE	DATE

Padres,