



**Authorization & Policies**

Student Name: \_\_\_\_\_ Enrollment Date: \_\_\_\_\_

Elementary School: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Days Attending: \_\_\_\_\_

Student Address: \_\_\_\_\_

Parent / Guardian Name & Phone Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Enrollment Information:** I give permission for ALD to release my child to be transported to

(Name of Hospital) \_\_\_\_\_

(Hospital Address) \_\_\_\_\_

\*(Hospital Phone Number) \_\_\_\_\_ or to the nearest hospital by ambulance in the event of an emergency. Initial \_\_\_\_\_

**\*First Aid/CPR:** I give permission for the Staff of the ALD Program to act on my behalf and provide needed medication and assistance. Initial \_\_\_\_\_

**\*In the event of an emergency:** I give ALD permission to act on my behalf and provided needed medication and assistance. Initial \_\_\_\_\_

**\*In the event of after school activities being cancelled,** ALD will also be cancelled. Initial \_\_\_\_\_

**\*In the event of after school activities being cancelled,** you are to follow emergency care card procedures. Initial \_\_\_\_\_

**\*Picture taking permission slip:** I give ALD permission and consent for ALD to take pictures / video of my child during program hours and activities. I further give permission and consent that any such photographs / video may be used by the ALD Program to illustrate and promote the ALD Program's website, Facebook page, or for the purposes of brochures and advertisements. Initial \_\_\_\_\_

**\*Release of Records:** I authorize ALD to access and review all health and educational records. Including but not limited to, an IEP, disability evaluations and test data for the purpose of providing instruction to my child. Initial \_\_\_\_\_

**\*Medications:** I understand that in order for my child to be given medications (prescriptions and/or over the counter medications) I must provide written authorization by the physicians and parent. Initial \_\_\_\_\_

**\*Computers / Video:** I give permission for my child to use or view computer / technology equipment during their time at ALD. I understand that the site coordinator monitors all exposure. Initial \_\_\_\_\_

I have read and initialed the above authorization and policies

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*All students must have a completed form on file in order to attend the Aligning the Learning Date Program (ALD). Please return your completed form to [TaraALDprogram@gmail.com](mailto:TaraALDprogram@gmail.com).**