

SECTION 1

GENERAL INFORMATION

Student Name: _____

School: _____ Student ID: _____ GPA: _____

DoB: _____ Sex: _____ Gender identity: _____

Race/Ethnicity:

- | | |
|--|--|
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> American Indian or Alaska Native |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Native Hawaiian or Pacific Islander |
| <input type="checkbox"/> White | <input type="checkbox"/> Two or More Races |
| <input type="checkbox"/> Asian | |

Grade: 4th 5th 6th

Home Address: _____

Home Phone: _____ Cell Phone: _____

Emergency Phone: _____ E-Mail: _____

Does your child receives free lunch? YES NO

Does your child receives reduced cost lunch? YES NO

Does your child receives English Language Learning support? YES NO

Does your child has additional service needs? YES NO

Please share the additional support need you require

SECTION 2

EMERGENCY MEDICAL TREATMENT CONSENT

The purpose of this section is to enable students to receive emergency medical or dental treatment should they become ill or injured. In the event of an emergency, 21st Century Pathways Program staff will attempt to reach the parent/guardian first.

In the event of reasonable attempts to reach the parent/guradian or emergency contact have been unsuccessful. I give my consent for my child/participant to receive any treatment deemed necessary by a licensed medical doctor or dentist and the transfer of the student to a hospital in the area. This authorization does not cover any of the cost associated with the treatment

MEDICAL HISTORY

Please provide information concerning the student's medical history and describe any physical impairments or conditions (including any allergies) requiring the use of medications and for which physicians should be alerted. Also list any medical conditions of which the Pathways staff should be aware and any medications currently used by the students that will be brought to the program.

MEDICAL CONDITIONS

MEDICATIONS (DOSE/FREQUENCY)

ALLERGIES

DOCTOR'S NAME: _____

PHONE NUMBER: _____ LOCATION: _____

SECTION 3

PARENTAL INFORMATION, CONSENT AND RELEASE

Parent/ Guardian Name: _____
First Name Middle Init. Last Name

Home Address: _____

Primary Phone: _____ E-Mail: _____

Language Spoken (check all that apply):

- English Spanish Other: _____

CONSENT AND RELEASE

My child has permission to walk home if they will attending Pathways activities after school.

My child will be picked-up (list name below if not written above)

First Name Middle Init. Last Name

WAIVER OF PARTICIPATION, COMMUNICATION, WAIVER OF LIABILITY, ASSUMPTION OF RISK, RELEASE OF CLAIM AND RETRIEVAL OF PARTICIPANT DATA FOR PROGRAM EVALUATION

I give permission for my child/student to attend the program and all the required yearly activities including field trips. The program begins September 1st and ends August 31st. Details located at the 21stcclcpathways.org website and attached to program application.

I give permission for my child/student to leave on their own following the program dismissal or follow the pick-up arrangements indicated above.

I understand that the information in this application will be used by the Pathways program staff to communicate with parent/guardian and program participant. Similarly, participant information will be used to report students improvements as mandated by ISBE including but not limited to attendance and academic progress.

I give permission for my child/student to be contacted and engage in communication with the program via but not limited to phone calls, BAND Messaging App, Remind, Google Suite for Education (messaging/video conference), and official website/social media.

I authorize the 21st CCLC Pathways staff to act on my behalf in case of any emergency, accident or illness. I release Northeastern Illinois University, the Chicago Public Schools, District 99 and the 21st Century Pathways staff from any liability or claims out of or in any way connected with this program.

I understand that my signature below gives Northeastern Illinois University permission to contact, exchange and gather information (including IAR and grades) on my enrolled child. This information will not affect my child's admission; it will be used to design a program that meets my child's needs and for program evaluation purposes.

I also grant full permission for Northeastern Illinois University to publish any photographs or films bearing my child's likeness and/or publish my child's first name withing the text of promotional materials connected with programs at the Center for College Access and Success. The content collected could be published for online and printed materials such as program webpage, internal network and posters to promote the program.

The undersigned represents that I am the parent/guardian of the minor and that I have full legal authority to execute the following consent and release participant form.

SIGNATURE

A signature permission form is necessary for participation in the program.

Student/Participant Signature Date

Parent / Legal Guardian Signature Date

SECTION 4

