DIVISION OF YOUTH SERVICES

DEPARTMENT OF COMMUNITY & CULTURAL AFFAIRS
COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

FYEP – Youth Services Program

Kagman Community Center, P.O. Box 501000 C.K., Saipan, MP 96950

KAGMAN COMMUNITY CENTER
AFTER SCHOOL PROGRAM REGISTRATION FORM

Participants must be 5 – 12 years old (Group A) or 13 – 17 years old (Group B).
Volunteer Program is also available for youth ages 13 years old and above, please ask FYEP Staff for details.

REQUIRED DOCUMENTS:

☐ Complete Registration Form.
☐ Copy of the Child's valid Health Insurance, or 24-Hour Student Coverage for the present school year.
☐ Copy of the Child's Health Certificate.
☐ Copy of the Child's School ID.

Note: *Application will be considered complete when all items listed above are submitted.*

Please list all Child Participants

Last Name	First Name	Gender	Citizen-ship	Ethnicity	Age	Date of Birth	Village

Parent, Legal Guardians and/or Emergency Contacts that would be allowed to pick up Child(ren):

	Parent/Legal Guardian 1	Parent/Legal Guardian 2	Emergency Contact (other than Parent/Legal Guardian)	Emergency Contact (other than Parent/Legal Guardian)
Print Name				
Relationship				
Telephone Number				
Other Contact #				

ADMINISTRATION 237-1000/01/02/03 FAX: 664-2566
CHILD PROTECTIVE SERVICES 237-1005 (06-14)
JUVENILE PROBATION UNIT 237-1024 (25-30)
FAMILY & YOUTH ENHANCEMENT PROGRAM 237-1015/16/17/18

Child lives with (mark all that apply): ☐ Father ☐ Mother ☐ Step Parents ☐ Foster
☐ Legal Guardian _____ ☐ Other _____
(Print Name) (Print Name)

Primary Language: _____ Secondary Language _____

Accommodation:

Does your child(ren) need any special help? (Ex: "Joseph gets distracted quickly, needs a buddy system to keep him focused.")

_____

_____

Allergies:

(1) Food: _____

(2) Medicine: _____

Medical Care:

Does your child(ren) need medical care or under any medication(s)? ☐ Yes ☐ No

If yes, please indicate what staff/volunteers needs to be aware of to better serve your child(ren). (Ex: "My son Johnny has asthma and needs to use his inhaler every 3 hours.")

_____

_____

Family Health Care: Physician's Name: _____ Phone #:_____

Address: _____ Medicaid: ☐ Yes ☐ No

Health Insurance# _____

Parent or Guardian Signature: _____ **Date:** _____
(Print & Sign Name)

Activity : **AFTER SCHOOL PROGRAM**
Days : Tuesdays, Wednesdays and Thursdays
Venue : Kagman Community Center

PARENTAL CONSENT

I, _____, parent/legal guardian of _____, hereby give permission for my child to participate in the After School Program coordinated by DCCA-Division of Youth Services (DCCA-DYS) at the Kagman Community Center.

WAIVER OF LIABILITY

I, _____, parent/guardian of _____, a participant at the DYS Kagman Community Center After School Program, do hereby assume all the foregoing risks and accept personal responsibility for any damages or injuries which may arise from my child participating in the DCCA-Division of Youth Services After School Program. I discharge ALL claims, demands, causes of actions, suits or judgments against the Department of Community and Cultural Affairs, Division of Youth Services, it's Administrators, Directors, Agents, Coordinators, staff, trainees, volunteers and other partner agencies and organizations involved in the coordination and implementation of program(s).

MEDIA RELEASE

I, _____, parent/guardian of _____, do hereby give consent and authorize employees, volunteers and/or partner agencies of the DCCA-DYS to take video images, photographs, audio recordings, or any other visual or audio reproduction of my child indicated above while participating in activities sponsored by DCCA-DYS to be used, distributed, or shown as DCCA-DYS sees fit. Such distribution may include, but not limited to DCCA-DYS' media publications such as newspaper or magazine articles, news reports, agency brochures, websites, grant reporting, etc.

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EMERGENCY MEDICAL AUTHORIZATION

I, _____, parent/guardian of _____, do authorize DCCA-DYS, in the event that I cannot be contacted or if any urgency dictates, to act *in loco parentis* for the Child in respect of any circumstances, including any accident or illness, which may necessitate medical treatment, including surgery, and on my behalf to authorize any such treatment or surgery which they, in their sole discretion, (which discretion shall not be unreasonably exercised), may deem necessary. Medical treatment for the Child may also include dental surgery, x-ray, blood transfusion, anesthetic and medication provided any such medical treatment is performed by a duly licensed practitioner. I hereby accept full liability for all costs incurred through such medical treatment for my child.

I acknowledge that I have read and fully understood the contents of the Consent, Waiver of Liability, Media Release and Emergency Medical Authorization forms. By affixing my signature below, I agree to the terms and conditions stated above. I also understand that my child is bound to abide to the RULES and REGULATIONS set forth by the program.

Parent or Guardian Name: _____
(Print Full Name)

Signature: _____ Date: _____

For Office Use Only

Enrollment Date and Time: _____ Initials: _____

Date Withdrew: _____ Reason: _____