



Community Partner Learning Place

Authorization to Release Education Records and Consent Form

The students listed below are participating in the programs at 2NOT1 Rites of Passage located at 822 So. 15th Street, 40210 hereafter referred to as the Organization. By signing this form, I am giving the Organization staff permission to communicate regarding services offered to me and/or my family, with the Jefferson County Public Schools (JCPS). I hereby authorize JCPS to release the education records of the students listed below to the Organization. **The records to be released are the student's name, student ID number, school, address, grade level, State required assessment scores, classroom test scores, grades, attendance, suspensions, early childhood work sampling scores, kindergarten readiness, ACT scores, graduation readiness, college readiness, career readiness, senior transition, comprehensive school survey data, student login and password, and all instructional information gathered through computer-based intervention software.** I understand that the Organization has agreed to keep these records confidential.

I understand that by authorizing the release of this information, it will be used for the sole purpose of providing and enhancing services to me, my family, and/or my child and to avoid duplication between the agencies. The disclosure of information will be limited to staff at the Organization and JCPS.

The students listed below will _____ will not _____ participate in the eLearn Olympics sponsored by the Louisville Central Community Center (LCCC), 1300 West Muhammad Ali Blvd, Louisville, KY 40203. If the students listed below will participate in the LCCC eLearn Olympics, I authorize LCCC to communicate with JCPS regarding the participation of the students in eLearn Olympics and I hereby authorize JCPS to release the following education records of the students listed below to LCCC: **Study Island student ID and password, and all information and intervention data contained in Study Island.** I understand that LCCC has agreed to keep these records confidential except to the extent required to award prizes in eLearn Olympics and to publicly recognize the students for prizes won.

There may be times when JCPS, the Organization or the news media may take photographs (or other digital images) of students participating in activities. Those images may appear in JCPS's or the Organization's publications including electronic publications or in the news media for education related stories. By signing this form, I authorize JCPS and the Organization to use the name and image of the students listed below for these purposes and for the purpose of providing community recognition.

I understand that JCPS and the Organization are independent parties. I understand and agree that JCPS shall have no liability for the acts or omissions of the Organization, their employees and volunteers. I have read and understand the contents of this form. I have received a copy, and I agree to its provisions. I understand that I may revoke this authorization at any time by written request.

I understand that this authorization will remain in effect until revoked by me in writing and delivered to the address below.

Print Name of Parent/Guardian: _____
(or Student if 18 or over)

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Please print students' Name, Current School and Grade:



Registration Packet

CHILD'S INFORMATION

Child's Full Name: _____

Date of birth: _____ Age: _____ Sex: _____ Grade: _____

Nickname _____

Current Address: _____

City: _____ State: _____ Zip: _____

PARENT/LEGAL GUARDIAN INFORMATION

Child lives with whom: _____

Parent name: _____

Current Address _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

E-Mail: _____

Is there a court order protecting custody of this child? *(If so, a copy must accompany the registration form)*

EMERGENCY CONTACT

Name other than parent/legal guardian: _____

Cell Phone: _____ Home Phone: _____



Registration Packet

PICK UP LIST (MUST BE OVER THAN 18)

Name: _____ Relationship to child _____

Cell Phone: _____ Home Phone: _____

Name: _____ Relationship to child _____

Cell Phone: _____ Home Phone: _____

MEDICAL INFORMATION

Family

Physician: _____

Address: _____

Phone: _____

City: _____ State: _____

Zip: _____

Medical Insurance: Yes or No (Circle One)

Insurance Company: _____ Policy

Number: _____

SPECIAL NEEDS AND CIRCUMSTANCES

Is your child prone to breakdowns or fits? Yes or No (Circle one)

If yes what are the triggers for your child: _____

Are there any other circumstances that could cause your child to be withdrawn, act out, or display inappropriate behavior during the program? Yes or No (Circle one) If yes please explain: _____



Registration Packet

HEALTH HISTORY

(Check all that apply)

- Asthma Diabetes Fainting Spells Heart Trouble
 Convulsions Bleeding Disorders ADD/ADHD Sports Restrictions
 Allergic To Insects Allergic Reactions To medications None of these apply

Explain if any of the above apply: _____

IMMUNIZATIONS

(Check all that apply)

- Tetanus Toxoid Diptheria Polio Mumps
 Measles Pertussis Rubella

ADDITIONAL MEDICAL INFORMATION: _____

Does your child have difficulty with any of the following? Check all that apply

- Eyes Ears Nose Throat
 Lungs Digestion Other _____

Does your child have a condition that requires medical attention? Yes or No (Circle one)



Registration Packet

Name of medication:

Provide instructions for dosage: _____

Does your child wear glasses or any other medical appliances? Yes or No (Circle one)

If yes please specify: _____

Does your child have any restrictions of activity for medical reasons? Yes or No (Circle one)

If yes please specify: _____

Are there any foods your child should avoid? Yes or No (Circle one)

If yes please specify: _____

MEDICAL EMERGENCY AND ADMINISTRATION OF MEDICAL SIGNATURE

In the event of illness or accident in the course of camp, I request that measures be instituted without delay as judgment of personnel dictates, with the understanding that the family will be notified as soon as possible, and I hereby authorize the doctor or hospital to which my child may be taken (and whomever they may designate as their assistants) to perform any emergency procedure or operation, to give treatment, and to administer an anesthetic to my child during his or her stay at the program.

I further give authority to the camp to administer over-the-counter medication in the proper dosage to my child if needed (e.g. Tylenol, Motrin, Benadryl, etc...) and to administer other medication as prescribed by a physician without my further consent.

Parent/Legal Guardian Signature: _____ Date: _____

Print Name: _____



Registration Packet

FIELD TRIP AND PHOTO AGREEMENT

The camper herein described has my permission to engage in all activities (including swimming) and daytrips, except as noted by me and/or the physician.

Exceptions noted by parent and/or physician: _____

I further give my permission for the 2NOT1 Inc. to provide daily meals and transportation. I also give my permission for my child's photo to be used for publication in marketing, grant applications, and any other promotions for 2NOT1 Inc. and Rites of Passage program.

Parent/Legal Guardian Signature: _____ Date: _____

Print Name _____

WAIVER/RELEASE OF LIABILITY

I (we) _____, parent/guardian of camper participant _____,

agree and understand that some activities may be hazardous. I recognize there are risks inherent in camps, including but not limited to injuries and death. As parent/guardian of the camper named herein, I agree to his/her participation in camp activities and hereby agree to indemnify and hold harmless the 2NOT1 organization, Plymouth Community Center and their officers, directors, agent volunteers, and employees against any liability resulting from an injury that may occur to the participant while participating in group activities. As parent/guardian I further agree to indemnify 2NOT1 Inc. for any damages incurred arising from any claims, demands, actions, or causes of actions by the camp participant. As parent/guardian, I hereby agree to pay all costs associated with medical care and transportation for said child participant.

I HAVE CAREFULLY READ THE ABOVE LIABILITY RELAESE AND SIGNED IT WITH FULL KNOWLEDGE OF ITS CONTENTS AND ITS SIGNIFICANTS.

Parent/Legal Guardian Signature: _____ Date: _____

Print Name _____



February 2017

Dear Parent(s):

2NOT1: *Fatherhood & Families, Inc.* would like to introduce you and your youth to an innovative program known as **theBLUEPRINT** Rites of Passage Program (ROP).

ROP is a mentoring program designed to support black male achievement of youth transitioning from elementary to middle school. ROP consists of trained adult male mentors, weekly discussions on various topics such as community violence, conflict resolution, child/parent relationships, in-school/at home behavior, and study skills. ROP guidelines include confidentiality, respecting opinions, and respectful disagreement. In addition, **theBLUEPRINT** is a key component of ROP and is implemented during the sessions.

theBLUEPRINT was created to help youth navigate their life. **theBLUEPRINT** will help your youth look at himself and develop strategies to successfully deal with life obstacles.

theBLUEPRINT focus areas:

- **Support recognition** to help the boys recognize support in their lives and how to take advantage.
- **Core Competencies** are the tool to empower the boys to make good decisions.
- **Positive Male Mentors** intergenerational discussions help give the boys the “context of life.”
- **Connection to resources** assist the boys understand and connect to available resources.

Your youth is invited to participate in this black male achievement program. **ROP** is offered at the **Ray Barker Economic Empowering Center, 822 South 15th Street, Louisville, KY 40210** beginning on **Sunday, February 26, 2017** from **2 pm until 4 pm**. This program is offered at **no cost** to you. However, a mandatory **Parent Orientation** meeting is scheduled for **Friday, February 24, 2017** from **6 pm to 8 pm** **OR** **Saturday, February 25, 2017** from **10 am until 12 pm** at **822 South 15th Street 3rd Floor Board Room**. **(PLEASE PICK THE DATE THAT WORKS FOR YOU)** This meeting is **MANDATORY** and is required for your youth’s participation in ROP.

If you are interested in enrolling your youth, please complete the attached application. Once the application is complete, contact Dr. Deonte Hollowell at (502) 855-1348 for drop off/pick up instruction.

Thank you in advance for your interest in this innovative program. We look forward to working with your youth.

Dr. Georgia A. Turner
2NOT1 Executive Director
(502) 509-9637

