Wampanoag Tribe of Gay Head (Aquinnah) Education Department
2021-2022 After-School Program Registration Packet

This is a registration packet for a Tribal child to attend the WTGH(A) After-School Program, also referred to as ASP. The After-School Program will begin **Monday, September 20** and will run Monday–Friday, 3:15PM–5:00PM, with pick-up time ending at 5:15PM. Please ensure that your child meets the following requirements before filling out the packet:

- is a registered Tribal member of the Aquinnah Wampanoag Tribe
- is enrolled in Grades K-6 for the school year
- will be 5 years of age by the end of the 2021
- is capable of using the bathroom themselves (potty-trained)

Note that the Registration Packet contains multiple forms, all of which are required. Please submit the forms and any accompanying documents to the Education Department. You may refer to this checklist and ensure you have all the documents:

- After-School Program General Registration Form
- Policies and Procedures Acknowledgement*
- COVID-19 Survey
- COVID-19 Policy and Protocol Acknowledgement*
- Dismissal/Release Form
- Transportation Permission/Release of Liability Form
- Photo/Video & Social Media Release Form
- Permission to Administer First Aid/Emergency Services Form
- ASP Illness Medical Form
- ASP Emergency Procedure Card
- Immunization Record
- OR Refusal to Vaccinate Form

*you only need to submit one per family

Once you have completed this packet, please submit it and the accompanying documents to the Education Department. **Registration is currently rolling. Please check with staff about enrollment availability.**

**By mail:**
WTGH(A) - Education Dept
20 Black Brook Rd
Aquinnah, MA 02535
ATTN: Jade Maak

**In-person:**
Contact Jade to arrange a meeting
508-560-1894 OR
eduspec@wampanoagtribe-nsn.gov

Program changes may occur and availability may be limited due to the ongoing COVID-19 pandemic
After-School Program General Registration Form

PART A. STUDENT INFORMATION
Child’s Full Name__________________________________________________________
Child’s Preferred Name/Nickname____________________________________________
Gender______________________ Age__________________ Date of Birth_____/_____/______
Enrolled School____________________________________________________________
Grade________________________

PART B. FAMILY INFORMATION
1st Parent/Guardian’s Full Name______________________________________________ Relation to Child____
Daytime Phone #_________________________________________ Can this number receive text messages? ☐ YES ☐ NO
Evening Phone #_________________________________________ Can this number receive text messages? ☐ YES ☐ NO
Email____________________________________________________________
Street Address________________________________________________________________
Mailing Address________________________________________________________

2nd Parent/Guardian’s Name____________________________________ Relation to Child____
Daytime Phone #_________________________________________ Can this number receive text messages? ☐ YES ☐ NO
Evening Phone #_________________________________________ Can this number receive text messages? ☐ YES ☐ NO
Email____________________________________________________________
Street Address (if different)________________________________________________________________
Mailing Address (if different)________________________________________________________________

Child resides with: ☐ 1st Parent/Guardian ☐ 2nd Parent/Guardian ☐ Both ☐ Other:____________________

Please list all siblings/household members that will also be enrolled in the program:
Name__________________________________________ Relation to Child____________
Name__________________________________________ Relation to Child____________
Name__________________________________________ Relation to Child____________
Name__________________________________________ Relation to Child____________
PART C. EMERGENCY CONTACTS

Please list all persons we may contact in the event of an emergency:

Name________________________ Relation to Child_________ Phone_________________
Name________________________ Relation to Child_________ Phone_________________
Name________________________ Relation to Child_________ Phone_________________

PART D. PROGRAM INFORMATION

Please select which days of the week your child will be attending ASP.

Note: Once enrolled, your child is entitled to come all 5 days. This is to inform staff of any recurring absences.

☐ Mondays  ☐ Tuesdays  ☐ Wednesdays  ☐ Thursdays  ☐ Fridays

Does your child have a current Individualized Education Plan (IEP)?  ☐ YES  ☐ NO
If yes, please submit a copy with this registration packet and it will be discussed personally with the Education Program Specialist. All information will be kept confidential.

Does your child have a current 504 Plan?  ☐ YES  ☐ NO
If yes, please submit a copy with this registration packet and it will be discussed personally with the Education Program Specialist. All information will be kept confidential.

Is there any other information about your child that you would like us to inform us about?

__________________________________________________________________________________________________

__________________________________________________________________________________________________

PART E. PARENT/GUARDIAN SIGNATURE

By signing this form and submitting it with the Registration Packet, I am registering my child for enrollment in the After-School Program for the 2021-2022 school year. I agree that all the information provided is true. In the event that any of the above information changes, I will inform the Education Department as soon as possible.

______________________________________________  ____________________________
Printed Name                                      Date

______________________________________________
Parent/Guardian Signature

2021-2022 ASP Registration Packet – Page 3 of 14
Policies and Procedure Acknowledgement

Please read over the After-School Program Policies and Procedures, which was given along with the Registration Packet. You may also refer to the PDF version on the Education website. This document explains what you may expect from the After-School Program, as well as what we expect of you as the responsible family. Please read it over with your child(ren).

I, the responsible adult, acknowledge that I have read over the After-School Program Policies and Procedures with my child(ren) and helped them to understand the program rules and expectations.

__________________________________________________  ________________________
Parent/Guardian Signature                  Date

As a student, I have read the program rules and expectations with my responsible adult and understand them fully. By signing below, I agree to abide by the program rules and guidelines as a condition of my attendance at the After-School Program.

__________________________________________________  ________________________
Student Signature                  Date

__________________________________________________  ________________________
Student Signature                  Date

__________________________________________________  ________________________
Student Signature                  Date

__________________________________________________  ________________________
Student Signature                  Date
COVID-19 Supplemental Registration Form

The Education Department continues to strive for a safe place for our children, and that includes taking measures in response to the COVID-19 pandemic. Please fill out the supplemental registration form below and we ask that you be completely honest in your answers. ALL RESPONSES WILL BE CONFIDENTIAL AND WILL NOT AFFECT YOUR CHILD’S ELIGIBILITY FOR ENROLLMENT.

Child’s Full Name: ___________________________________________________________________________________

Has your child traveled out-of-state in the last seven (7) days? □ YES □ NO
If yes, please state the date your child returned home: ___________________________________________________________________________________

Are those of eligible age in your household vaccinated?
☐ ALL are vaccinated ☐ SOME are vaccinated ☐ NONE are vaccinated

Please rate each statement below by marking the box:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>My child is comfortable wearing a mask for the duration of ASP.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>My child is familiar with mask-wearing protocols.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>My child is familiar with practicing safe social distancing.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>My child is capable of independent and thorough hand washing.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

By signing below, I agree that all of the information provided above is true.

__________________________________________________  __________________________
Parent/Guardian Signature                           Date

2021-2022 ASP Registration Packet – Page 5 of 14
COVID-19 Procedure and Protocol Acknowledgement

Please read over the COVID-19 Procedure and Protocol for Education Department: Programs and Families, which was given along with the Registration Packet. You may also refer to the PDF version on the Education website. This document explains what measure we are taking in response to the COVID-19 pandemic, as well as what we expect of you as the responsible family. We ask for your understanding that these COVID-19 Procedure and Protocols may change, and all families will be informed immediately of those changes. Thank you for working with us to create a safe space for our children in these uncertain times!

Full names of all enrolled students: __________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Please initial to agree to the following statements:

I agree to inform the Education Department staff of any COVID-like symptoms my child may be experiencing and will follow the protocol as described.  
Initials:________

I agree to inform the Education Department staff of any exposure to COVID-19 my child or any person in their household has experienced.  
Initials:________

I agree to share COVID-19 screening test results as needed, based on the Procedure and Protocols.  
Initials:________

By signing below, I acknowledge that I have read over the Education Department COVID-19 Policies and Protocols and agree to the initialed statements above.

__________________________________________________  ______________
Parent/Guardian Signature Date
Dismissal/Release Form

Child’s Name: ________________________________

Please fill in the names of persons (other than the parent(s)/guardians) that have your permission to pick up your child from the After-School Program. Individuals NOT listed below will not be able to pick up your child from our program.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone</th>
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</thead>
<tbody>
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</tbody>
</table>

Does your child have permission to walk or bike home BY THEMSELVES at the end of After-School Program (5:00pm)?

☐ YES  ☐ NO

Is there anyone who is NOT permitted to pick up your child from our program?

If yes, the Education Department will reach out to discuss this matter. Any special instructions such as custody or restraining orders must be attached to this registration packet. All information will be kept confidential.

☐ YES  ☐ NO

________________________  __________________________
Parent/Guardian Signature  Print Name

You are entitled to change this list at any time. Changes must be made IN WRITING to be in effect.

Please inform Education Department staff if you would like to make changes or resubmit this form.
Transportation Permission/Release of Liability Form

I, the undersigned parent/guardian, understand and AGREE to allow my child to be transported by the Wampanoag Tribe of Gay Head (Aquinnah) to various locations on Martha’s Vineyard for activities involved with the After-School Program. These locations include but are not limited to public beaches, libraries, public playgrounds, and areas on Tribal lands. The Education Department staff will inform me of these trips via text.

I agree that the transportation of my child by the WTGH(A) will be at my own risk. I expressly, voluntarily, and knowingly release, agree to protect, hold harmless and indemnify the WTGH(A), its employees, representatives, officers, advisors, agents, members, and any and all individuals or organizations affiliated with the WTGH(A) from any liability, loss, damage, costs, claims, and/or causes of action, including but not limited to all bodily injuries, property damage, property loss, and/or theft of any property arising out of transportation of my child by the WTGH(A).

By signing below, I verify that I have read the above Release of Liability and have voluntarily signed with full understanding of its purpose.

__________________________________________  ______________________________________
Parent/Guardian Name (Print)  Child’s Name

__________________________________________  ________________________________
Parent/Guardian Signature  Date
Photo/Video Release Form

I, the undersigned adult parent/guardian, □ AGREE    □ DISAGREE to allow photos and/or videos taken of my child during the After-School Program to be used for the Wampanoag Tribe of Gay Head (Aquinnah) Education Department for their website, brochures, flyers, calendars and any other use deemed appropriate for the department’s use, including publishing in the Toad Rock Times. The pictures and/or videos will not be used by other organizations without my written consent.

__________________________________________  _______________________________________
Parent/Guardian Name (Printed)                                         Child’s Name

__________________________________________
Parent/Guardian Signature

_____________________
Date
Permission to Administer First Aid, Emergency Services

In the event of an emergency, injury or situation that requires medical attention, I request that the After-School Program staff make every effort to contact me and the listed emergency contacts. However, I/WE, the undersigned adult(s), authorize the After-School Program staff to obtain whatever medical attention is appropriate including the use of emergency medical technicians reached through 911 services for ________________________________.

Child’s name

Do you have medical insurance for this child? ☐ Yes  ☐ No

If YES, please fill out the following:
Insurance Company: __________________________________________________________
Policy Subscriber’s Full Name: ________________________________________________
Policy #: __________________________________________________________________

___________________________________________  _____________________________
Parent/Guardian Signature                        Date

___________________________________________
Parent/Guardian Signature
After-School Program Medical Form

Child’s Name: ____________________________  Birth Date: __________  Sex: _____  Age: _____

Pediatrician or Physician: ____________________________  Phone: ____________________________

Date of last physical examination: ____________________________

Dentist or Orthodontist: ____________________________  Phone: ____________________________

Health History: (Give approximate dates)

Conditions:  Allergies:  Diseases:  Other (Please specify):
☐ Frequent ear infections  ☐ Asthma  ☐ Mononucleosis
☐ Heart defect/disease  ☐ Hay fever  ☐ Chicken pox
☐ Convulsions  ☐ Poison ivy  ☐ Measles
☐ Diabetes  ☐ Insect sting  ☐ German measles
☐ Bleeding/Clotting disorder  ☐ Penicillin  ☐ Mumps
☐ Chronic Lyme disease  ☐ Alpha-GAL Syndrome (AGS)

Other chronic conditions or diseases: _____________________________________________________

Dietary Modifications (including allergies): __________________________________________________

Does your child use any of the following?  ☐ Eyeglasses  ☐ Contact lenses  ☐ Hearing aid

List any medications taken by your child and reason for taking:

Medication: ____________________________  Reason: ____________________________
Medication: ____________________________  Reason: ____________________________
Medication: ____________________________  Reason: ____________________________

I authorize my child to apply topical medications such as  ☐ SUNSCREEN,  ☐ CALAMINE LOTION, and  ☐ BUG/TICK REPELLENT under the supervision of the After-School Program staff.

Please initial here: ________________
Comments or Details of Above:
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed program activities except as noted.

____________________________
Parent/Guardian Name (Printed)  

____________________________
Child’s Name

____________________________
Parent/Guardian Signature

____________________________
Date

**EMERGENCY AUTHORIZATION:** I hereby ☐ **GIVE PERMISSION** ☐ **DO NOT GIVE PERMISSION** to medical personnel at the nearest urgent care to order x-rays, routine tests and treatment for my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician to hospitalize, secure proper treatment for, and to order injections of anesthesia and/or surgery for my child as named above.

____________________________
Parent / Guardian Signature

____________________________
Date

Name of Minor: ________________________________________________
## Immunization Record
(to be completed by child’s physician)

Required immunization must be determined locally. Please record the date (MM/YY) of basic immunizations and most recent booster doses:

<table>
<thead>
<tr>
<th>VACCINES</th>
<th>Date of Basic Immunization</th>
<th>Date of Last Booster</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria</td>
<td></td>
<td></td>
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<tr>
<td>Pertussis (Whooping Cough)</td>
<td></td>
<td></td>
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<tr>
<td>Tetanus</td>
<td></td>
<td></td>
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<tr>
<td>DPT or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus TD</td>
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</tr>
<tr>
<td>Diphtheria or Tetanus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Polio (Sabin) TOPV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injectable Polio (Salk)</td>
<td></td>
<td></td>
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<tr>
<td>Measles (hard measles, red measles, Rubella)</td>
<td></td>
<td></td>
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<tr>
<td>Mumps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella (German Measles or 3-day Measles)</td>
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<td></td>
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<tr>
<td>Most recent Tuberculin test given (TINE)</td>
<td></td>
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<tr>
<td>Other (specify):</td>
<td></td>
<td></td>
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</tbody>
</table>

______________________________  _______________________
Physician Signature             Date

*Or please attach a form with immunization records from your physician’s office with the signature of the physician.*
Refusal to Vaccinate

I have decided at this time to decline or defer the vaccines recommended for my child. I know I may readdress this issue with my child’s doctor or nurse at any time and that I may change my mind and accept vaccination for my child any time in the future. I acknowledge that by signing here I have agreed to tell all health care professionals in all settings what vaccines my child has not received because he or she may need to be isolated or may require immediate medical evaluation and tests that might not be necessary if my child had been vaccinated in the event of a medical emergency.

___________________________________________
Child’s full name

___________________________________________
Parent/Guardian Signature

____________________________
Date