

**SHADOW**  
**Students of Hornell Actively Discovering Our World**  
**APPLICATION AND CONTRACT**

Child's Full Name \_\_\_\_\_ Grade/School \_\_\_\_\_

Parent/Guardian's Full Name \_\_\_\_\_

Address \_\_\_\_\_

Phone: Mother/Guardian - Home \_\_\_\_\_ Work \_\_\_\_\_

Father/Guardian - Home \_\_\_\_\_ Work \_\_\_\_\_

**Emergency Contacts**

**Others Who May Pick Up My Child**

Name	Phone	Name	Phone

**Emergency Medical Information**

In the event of a medical emergency, the Site Coordinator should call:

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

In the event that I, or my child's physician cannot be reached in an emergency, I hereby give my permission to the physician/hospital selected by the SHADOW Program to secure proper medical treatment for my child.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Allergies and/or Special Needs**

*Please list any allergies to foods, bees, etc., and/or any special needs*

Allergy or Special Need	Reaction	Action To Be Taken

**Student Attendance and Dismissal Plan**

Day of the Week	Time	Early pick up (Time)	Walk Home	Picked Up	Bus Home
Monday	3:15-5:15 pm				
Tuesday	3:15-5:15 pm				
Wednesday	3:15-5:15 pm				
Thursday	3:15-5:15 pm				
Friday	3:15-5:15 pm				

*Please Note: Any change in the above dismissal plan on a daily, weekly or permanent basis MUST be given to the Site Coordinator IN WRITING by the parent or guardian.*

**Parent/Guardian Memo of Understanding:**

I have been given a Parent Handbook that provides information regarding the SHADOW Program, and I am aware of the policies explained within. I agree to comply with the policies outlined in the handbook, and will fulfill my responsibilities to provide current and accurate emergency information to SHADOW staff. I will encourage my child to participate fully and with appropriate behavior in activities and events planned by staff. I understand that failure to fulfill these requirements may result in my child becoming ineligible to remain in the program.

- I give consent for access to my child's records for the sole purpose of data collection for the Department of Education, in accordance with continued funding of the SHADOW Program. I understand that my child's name WILL NOT be used.  
**Yes No**
- I give consent for my child to be photographed for educational material, promotional articles or any other lawful purpose.  
**Yes No**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Student Memo of Understanding:**

I understand that I am expected to learn and follow the SHADOW program rules. In the event that I choose not to follow the rules, I may have to leave the program. The policy for discipline will be: 1) Verbal warning. 2) Conference with Site Coordinator and parent/guardian. 3) Extended time out of program or release from the program.

**RULES TO REMEMBER:** 1) Respect yourself 2) Show respect for adults and peers 3) Respect school property 4) Follow the school's rules of conduct 5) Be helpful to others in the program 6) Have Fun.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_