

Washington Elementary School  
**Creativity, Academics, Teamwork, for Success (C.A.T.S.)**  
Registration Form/Consent to Participate in C.A.T.S. Before & After School Program

For the 2024-25 after school program, students enrolling in the program need to commit to regular participation according to the school delivery plan in place (in-person or remote). More details are included in the Parent Handbook. Please complete the form below and return it to your son/daughter's classroom teacher. All students **must** return a completed consent form **before** participating in the C.A.T.S. program.

Student's Name: \_\_\_\_\_ Age \_\_\_\_\_ / Birth Date \_\_\_\_\_ / Grade \_\_\_\_\_  
Homeroom Teacher: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
(Please exact street address for busing purposes) (Town/State/Zip Code)  
Parent Name: \_\_\_\_\_ Parent Address: (if different from the student) \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Parent Cell Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_

Check one or both program(s) that your child will be attending:  morning Program  evening program  
**Transportation Information/Early Dismissal Consent**

- Please check if your son/daughter **will be riding** a bus home from C.A.T.S.
- Please check if your son/daughter **will NOT be riding** a bus home from C.A.T.S. because they live within a one mile **walking** distance of the school.
- Please check if your son/daughter **will NOT be riding** a bus home from C.A.T.S. because they will be **picked up** by: parent, guardian, or other designated person(s) listed on this form.

If you are picking up your son/daughter early from C.A.T.S., you (parent, guardian, or other designated person) must come in and sign him/her out.

Please list anyone who is allowed to pick up this student other than the parent or guardian. Include the names and phone numbers of people you trust to be responsible for your son/daughter after school in the event that C.A.T.S. is cancelled and you cannot be reached by phone.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

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Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Please list the student's current evening bus driver's name \_\_\_\_\_ and bus number \_\_\_\_\_

**Field Trip Consent/Press Release Consent**

Field trips are part of the before/after school educational program and part of the C.A.T.S. grant criteria. Adequate notice of field trips including destination, departure and return times will be provided for parents.

Photographs/video tapes of students participating in the C.A.T.S. program are used to promote the program through displays, press releases, newspaper articles, or television.

Please indicate if you give permission for your son/daughter to participate in these activities:

\_\_\_\_\_ Can \_\_\_\_\_ Cannot participate in field trips

\_\_\_\_\_ Can \_\_\_\_\_ Cannot be photographed for program promotion

**Grant Assurances**

The **C.A.T.S.** afterschool program is funded by a 21<sup>st</sup> Century Community Learning Center Grant. **Whether in-person or remote programming is delivered**, the grant guidelines **require students to attend the program regularly (for 2-4 days per week ) and parents are required to participate in 3 C.A.T.S. sponsored family events throughout the year.** Please sign below to agree to these requirements and to verify the information provided on this form.

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

**(Complete other side)**

# Emergency Medical Authorization

The purpose of this form is to enable parents to authorize emergency treatment for their son/daughter in the event he/she is ill or injured while under school authority, when parents cannot be reached. (For afterschool licensing purposes, 3 contacts are required)

People to be contacted in the event of an emergency if parent cannot be contacted:

1. Name: \_\_\_\_\_ Address: \_\_\_\_\_

Relationship \_\_\_\_\_ Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

2. Name: \_\_\_\_\_ Address: \_\_\_\_\_

Relationship \_\_\_\_\_ Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

3. Name: \_\_\_\_\_ Address: \_\_\_\_\_

Relationship \_\_\_\_\_ Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Physician/Clinic \_\_\_\_\_ Address: \_\_\_\_\_

City, State \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist/Clinic \_\_\_\_\_ Address: \_\_\_\_\_

City, State \_\_\_\_\_ Phone: \_\_\_\_\_

In the event reasonable attempts to contact parents have been unsuccessful, I hereby give consent for (1) the administration of any treatment deemed necessary by preferred physician/dentist as listed above; or, in the event the designated preferred practitioner is not available, by another licensed physician/dentist; and (2) the transfer of the child to \_\_\_\_\_ (Preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.

I understand medical information may be shared with appropriate school personnel as deemed necessary by the school administration.

List all allergies (medicines, food, etc): \_\_\_\_\_

List medicines and who is to give the medicine: \_\_\_\_\_

List any additional facts concerning the student's medical history, and any physical impairment to which a physician should be alerted:

\_\_\_\_\_  
\_\_\_\_\_

## Refusal to Consent

I do **NOT** give my consent for emergency medical treatment of my child. In the event of an illness or requiring emergency treatment, I wish the school authorities to take the following action:

\_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

## Additional Information

Please list any additional information the after-school personnel may need to know concerning this student's health, safety, or general well-being.

\_\_\_\_\_  
\_\_\_\_\_

The C.A.T.S. program is provided in partnership with the Gallipolis City School District, the Gallia-Vinton Educational Service Center, and the 21<sup>st</sup> Century Community Learning Center Grant.

In order to keep the After School Program safe and effective, class sizes will be limited.

## GALLIA COUNTY QUICK REFERENCE GUIDE TO LOCAL RESOURCES

**Please keep this Reference Guide for your records at home.**

### FOOD RESOURCES

- Vinton Baptist Church – 740-388-8454 (Mondays)
- Nazarene Church – 740-446-1772 (Thursdays)
- Kingdom Ministries – 740-388-8980 (last 3 Mondays)
- Cheshire Baptist Church – 740-367-7801 (3<sup>rd</sup> Monday)
- New Life Lutheran Church – 1-877-704-3663 (1<sup>st</sup> Tuesdays)
- Grace United Methodist Church – 1-877-704-3663 (3<sup>rd</sup> Tues)
- Outreach Center – 740-446-7555 (Tues/Thurs. -1<sup>st</sup> week/mo.)
- God's Hands At Work – 740-645-7609 (application necessary)
- Simpson Chapel United Methodist – 740-245-9140-3<sup>rd</sup> Wed

### DEVELOPMENTAL DISABILITIES

- Gallia County Board of DD – 740-446-6902
- Early Intervention – 740-446-6902
- Early Intervention **Referral** Contact – 1-740-371-3322
- Ohio Coalition for Children with Disabilities – 1-844-226-0535
- HOPE Intervention – facebook.com/hopeintervention
- OCALI – 614-410-0321 (or www.ocali.org)
- Area Agency on Aging - 1-740-245-5306 or aaa7.org
- Gallipolis Developmental Center – 740-446-1642
- Opportunities for Ohioans with Disabilities – 1-800-637-9341

### TRANSPORTATION

- Need A Lift – 740-709-0177 (Medicaid)
- On The Go – 740-645-2268 (Medicaid)
- Community Action Agency – 740-367-7341 (Medicaid)
- Senior Resource Center (wheelchair) – 740-446-7000

### SCHOOL DISTRICTS/SCHOOLS

- Gallia County Local School Board Office – 740-379-9085
- Gallipolis City School Board Office – 740-446-3211
- Ohio Valley Christian School – 740-446-0374
- Buckeye Hills Career Center – 740-245-5334
- Gallipolis Career College – 740-446-4367
- URG/Community College - 1 (800) 282-7201
- Guiding Hand School – 740-446-6903
- Gallia-Vinton Educational Service Center – 740-245-0593

### HOUSING RESOURCES

- Integrated Services Non-Emergency Assistance – (John) 800-321-8293
- Gallia Housing Authority (HUDD) - 740-446-0251
- Hopewell Health Centers – 740-446-5500
- Serenity House (Women's DV Shelter) – 740-446-6752

### HEALTH CARE

- Holzer Hospital/Clinic – 740-446-5937
- Jeanne Ingalls Family Practice – 740-446-7393
- Canaday Care – 740-446-2929
- Ohio Valley Physicians – 740-446-4600
- Gallia County Health Department – 740-441-2950

### DRUG/ALCOHOL ADDICTION TREATMENT

- Health Recovery Services – 740-446-7010
- Field of Hope Community Campus – 740-245-3051
- TASC of Southeast Ohio – 740-446-6471
- Spectrum Outreach Services – 740-446-2085
- Woodland/Hopewell Health Centers – 740-446-5500
- STEPS of Recovery – 740-441-9800

### MENTAL HEALTH TREATMENT

- Woodland/Hopewell Health Centers – 740-446-5500
- Wing Haven – 740-388-8567
- Integrated Services – 740-208-0138
- Mental Health Board – 740-446-3022

### SOCIAL SERVICES

- Child Protective Services – 740-446-4963
- Adult Protective Services – 740-446-7000
- Gallia County Courthouse – 740-446-4612
- Municipal Court – 740-446-9400
- Senior Resource Center – 740-446-7000
- Job & Family Services – 740-446-3222
- Community Action Agency – 740-367-7341
- Social Security Administration – 888-397-6343
- Gallia County Health Department – 740-441-2018
- Women, Infant, Child Clinic – 740-441-2977
- BCMH – 740-441-2039
- Legal Aid of Southeastern Ohio – 1-800-686-3669
- Family & Children First Council – 740-446-3022

### SAFETY/EMERGENCY SERVICES

- 911 Non-Emergency – 740-446-0025
- City Police – 740-441-6015 or 740-446-1313
- Sheriff's Office – 740-446-1221
- Gallipolis Fire Department – 740-446-1234
- State Highway Patrol – 1-740-446-2433
- Red Cross – 740-446-8555
- Crime Watch – 740-446-1242
- Coroner – 740-446-7711
- Portsmouth Ambulance – 740-354-3122

### MISCELLANEOUS

- Bossard Memorial Library – 740-446-7323
- License Bureau – 740-446-8510
- Extension Office – 740-446-7007
- Fairgrounds – 740-446-4120
- Landfill – 740-388-9740
- COAD/RSVP of the Ohio Valley - 740-286-4918