



2011-2012 Enrollment Forms

September 2011 – May 2012 (Actual Dates TBA)

- AileyCamp The Group
- Fifth & Sixth Grade Program
- Second through Fourth Grade Program

STUDENT CLASS PLACEMENT WILL BE DETERMINED BY PLACEMENT AUDITIONS
PLACEMENT AUDITION DATE TBA

**IN ORDER TO PARTICIPATE IN KCFAA PROGRAMS
REGISTRATION FEES MUST BE PAID,
ALL ENROLLMENT FORMS COMPLETED AND RETURNED
INCLUDING A SPORTS PHYSICAL TAKEN IN WITHIN THE PREVIOUS 2 YEARS**

Kansas City Friends of Alvin Ailey

Please Print - All information supplied is for KCFAA records.
 Second through Fourth / Fifth through Sixth / AileyCamp The Group

First Name	Last Name	Gender	Home Phone
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Address	City, State Zip	Work Phone
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Parent or Guardian Name	Relationship	Email address
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Age	Birth Date / /	Height	Weight	Short Size	Shirt Size	Leotard Size	Shoe Size
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What is the name of your child's school? _____ Current Grade _____

Does your child receive free or reduced lunch? (Circle one) Free Reduced

How are your child's grades this year? (Circle one) Excellent Fair Poor

1. How is your child's health? _____

	No	Yes	If yes, please explain
Has your child ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Does your child have asthma?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Does your child have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is your child allergic to any medications?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Does your child have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Does your child have any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Does your child have ankle, knee, back problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are your child's immunizations up to date?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is your child currently taking any medications?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Does your child have any other health issues? (Not mentioned above)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has your child had any physical injuries in the last 3 years?	<input type="checkbox"/>	<input type="checkbox"/>	_____

2. Ethnicity?

African American <input type="checkbox"/>	Caucasian <input type="checkbox"/>	Native American <input type="checkbox"/>
Asian <input type="checkbox"/>	Hispanic <input type="checkbox"/>	Other <input type="checkbox"/>

3. Your child lives with? (Please check all that apply)

Both Parents <input type="checkbox"/>	Father <input type="checkbox"/>	Aunt/Uncle <input type="checkbox"/>
Mother <input type="checkbox"/>	Grandparents <input type="checkbox"/>	Other <input type="checkbox"/> Please Specify _____

3. Family Income?

Less than \$10,000 <input type="checkbox"/>	\$10,000 - \$19,999 <input type="checkbox"/>	\$20,000 - \$29,999 <input type="checkbox"/>	\$30,000 - \$39,999 <input type="checkbox"/>
\$40,000 - \$49,000 <input type="checkbox"/>	\$50,000 - \$59,000 <input type="checkbox"/>	\$60,000 - \$69,000 <input type="checkbox"/>	More than \$70,000 <input type="checkbox"/>



Consent and Release

I hereby waive and release KCFAA and its officers, agents, volunteers and employees from all acts or omissions resulting in any physical injuries, medical treatment, or other damages to myself or any minors of whom I am parent or legal guardian, resulting from participation in KCFAA programs. I further waive and release KCFAA and its officers, agents, volunteers, and employees from any damages sustained by the aforementioned or any guests of the aforementioned as a result of any condition, act, omission or accident on or at 1714 East 18th Street, Kansas City, MO 64108 or any other premises upon which any activity related to KCFAA takes place.

This release is granted in perpetuity. I agree to the above and have read the policies and procedures and agree to abide by the terms and conditions therein including the "CODE OF CONDUCT."

Child's Name (print): _____

Parent/Guardian Name (print): _____

Parent/Guardian Signature: _____

Date: _____

How did you hear about our programs?



Policies & Procedures Arrival & Dismissal Procedures

Name of Child: _____

D.O.B.: ____/____/____ Age: _____

My child will arrive at KCFAA via: (please check the approved method)

- Public Transportation
- Unsupervised walk
- Car-Parent/Guardian/Other: _____
- Supervised walk: Escorted by:

_____/_____
(Name of escort) (Relationship to child)

Other: (please describe)

At dismissal time, my child will depart from KCFAA via: (please check the approved method)

- Public Transportation
- Unsupervised walk
- Car-Parent/Guardian/Other: _____
- Supervised walk: Escorted by:

_____/_____
(Name of escort) (Relationship to child)

Other: (please describe)

Individuals authorized for pick-up

1. _____/_____
(Name) (Relationship to child)

2. _____/_____
(Name) (Relationship to child)

3. _____/_____
(Name) (Relationship to child)



POLICIES & PROCEDURES STANDING ORDER FOR HEALTH CARE AND FIRST AID EMERGENCIES

Care plan for mildly ill children:

If a child arrives sick or becomes sick during the class session, she/he will be placed in a quiet area in the program facility to rest. Depending on the seriousness of the symptoms, the child's parent/guardian may be called to pick her/him up from the studio. For the protection of other children and staff, children must be kept at home if any of the following symptoms are present:

- Temperature of over 100 degrees orally.
- Intestinal illness accompanied by diarrhea or vomiting.
- Any medically undiagnosed rash.
- Discharge from eyes or ears, or profuse nasal discharge.
- Open, non-treated wounds or sores.
- Sore throat or persistent cough.

Infection Control:

To prevent illness from spreading, KCFAA will adhere to the following procedures:

- Children will be encouraged to cough/sneeze into their upper sleeve or elbow or cough/sneeze into a tissue.
- Staff and children will wash their hands before beginning the day, before preparing, handling, or eating food, after using a tissue or after contact with any body secretions.
- Children will not share cups, spoons, etc. Disposable eating utensils will be used for meals and snacks.
- Children will not share personal items such as hats, hair combs, etc.
- All staff and children will learn and follow the hand-washing procedure of using liquid, powder, or bar soap under running water with friction. Hands will be dried with disposable paper towels.

Plan for emergency treatment of illness or injury:

If a child appears to be seriously ill or injured and needs immediate medical attention, the KCFAA staff will contact 911 emergency services and the parent/guardian. If it is determined that the child does not need to be seen immediately at the hospital, the child's parent/guardian shall pick up the child and transport her/him to a physician/hospital for follow-up examination at a later time.



**POLICIES & PROCEDURES
MEDICAL AUTHORIZATION FORM**

I am the parent or legal guardian of_____.

I give permission for him/her to engage in all KCFAA Program activities except as noted in writing by me or a licensed physician.

I give permission for a physician selected by KCFAA Staff to examine, order x-rays, perform routine tests, and perform treatment for the health of this child.

In the event I cannot be reached in an emergency, I give permission for a physician selected by a KCFAA Staff to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for this child.

I authorize any hospital, physician, medical practitioner, clinic, or related facility to furnish to any interested insurance company, or anyone acting on its behalf, all information concerning medical, dental, and hospital records concerning this child, to be used for the purpose of evaluating claims for benefits.

Signature of Parent/Guardian

Date of Signature

EMERGENCY INFORMATION FORM

This information is critical and will enable KCFAA Staff to contact someone in case of an emergency. Please fill out completely and accurately.

IN CASE OF AN EMERGENCY, PLEASE CONTACT:

Name of emergency contact

Phone

Relationship to child

Name of emergency contact

Phone

Relationship to child

Insurance

Insurance Policy Holder

Insurance Company/Policy #



Policies & Procedures
Authorization to Administer Medication to Campers
(To be completed by parent/guardian)

Name: _____

Date of birth: _____ Age: _____

Parent/Guardian Name _____ Relationship to participant _____

Business Phone _____ Home Telephone _____ Cell Phone _____

Emergency Contact Name _____ Relationship to participant _____

Business Phone _____ Home Telephone _____ Cell Phone _____

Please list **all** food/drug/environmental allergies: _____

Name of medication: _____ Dosage: _____

Expiration date: _____

How often must medication be taken? _____

Is your child authorized to self-medicate? Yes No

Amount to be given: _____

Describe any special storage requirements: _____

Describe any specific directions or special precautions for administering medication (e.g. "take on empty stomach/with food"): _____

Describe any possible side effects/adverse reactions: _____

List other medications the participant may take (at parent's discretion, e.g. Tylenol for minor headaches): _____

Doctor/Physician's name: _____ Phone: _____

Parent/Guardian Signature

Date



Photograph Release Form

I understand that signing this student photograph release form allows my child, _____, (print name) who is a KCFAA program participant to be photographed and/or videotaped by the KCFAA staff, volunteers and the media for the purpose of media coverage, promotional activities, or documentation.

I understand that this release form does not guarantee the use of my child's quotes, photograph or videotape appearance in any publication, broadcast, or release.

I hereby grant my permission to members of the media and staff or assigns of Kansas City Friends of Alvin Ailey to use my child's quotes, photographs and/or videotape prior to use of publication.

Parent or Guardian Signature

Date of Signature

Field Trip Acknowledgement and Permission Form

I am the parent or guardian of _____
(Please print your child's name)

I agree that he/she can participate in programs sponsored by the Kansas City Friends of Alvin Ailey, Inc. In addition, I agree that he or she can participate in all KCFAA scheduled fieldtrips. Please check with the Director of Artistic and Educational Programs for fieldtrip schedule.

I have read and understand this form. I agree that if I have any questions about this form or these plans, I will contact the Michael Joy, Director of Artistic and Educational Programs at (471-6003 x20) to get more information before signing it. I agree to instruct my child to obey the directions of Michael Joy, KCFAA staff, and the KCFAA chaperones, follow all safety rules, and to use their best behavior at all times.

In return for these special activities, I agree on my behalf, and on behalf of the above-named student, not to sue Kansas City Friends of Alvin Ailey, Inc., its officers, agents, servants, and employees for any amount in excess of the valid and collectible insurance in force and effect with respect to KCFAA Programs. I also agree to hold harmless Kansas City Friends of Alvin Ailey, Inc., and its officers, agents, servants, and employees, from any and all liability in excess of said insurance coverage.

This is not intended to and shall not be construed to release any insurance company or any third party from any obligation to pay any liability insurance or other benefit.

This permission slip is valid for the period of two years after the date of signature.

Parent or Guardian (print)

(____)_____
Phone Number

Date of Signature

Parent or Guardian (signature)

Kansas City Friends of Alvin Ailey

2011-2012 KCFAA DANCE QUALIFYING PHYSICAL EXAMINATION CLEARANCE FORM

Student Name: _____ Birth Date: _____ Age: _____ Gender: M / F

Address: _____

Home Telephone: _____ - _____ - _____

School: _____ Grade: _____ Sports: _____

I certify that the above student has been medically evaluated and is deemed to be physically fit to: (Check One Box)

(1) Participate in all dance activities without restrictions.

(2) Requires further evaluation before a final recommendation can be made.

Additional recommendations for KCFAA or parents: _____

(3) Not cleared for: Physical Activities _____

Reason: _____

I have examined the above named student and completed the Dance Qualifying Physical Exam as required by KCFAA.
A copy of the physical exam is on record in my office and can be made available to KCFAA at the request of the parents.

Attending Physician Signature: _____ Date of Exam: _____

Print Physician Name: _____

Address: _____

Office Telephone: _____ - _____ - _____

**COPY THIS CLEARANCE FORM FOR THE STUDENT TO
RETURN TO KCFAA AND KEEP THE ENTIRE
3-PAGE FORM IN THE STUDENT'S MEDICAL RECORD.**

IMMUNIZATIONS [tD (required by age 12 or entry to 7th grade) ; MMR (2 required); hep B (3 required); varicella (or history of disease); poliomyelitis; influenza]

Up-to-date (see attached school documentation) Not up-to-date / Specify _____

IMMUNIZATIONS GIVEN TODAY: _____

EMERGENCY INFORMATION

Allergies _____

Other Information _____

Emergency Contact: _____ Relationship _____

Telephone: (H) _____ - _____ - _____ (W) _____ - _____ - _____ (C) _____ - _____ - _____

Personal Physician _____ Office Telephone _____ - _____ - _____

QUALIFYING PHYSICAL HISTORY FORM

DATE OF EXAM _____

Student Name: _____ Birth Date: _____ Age: _____ Gender: M / F
 Address: _____
 Home Telephone: _____ - _____ - _____
 School: _____ Grade: _____ Dance: _____

History

Circle Y for Yes or N for No
 unknown.

Circle Question Number (1. etc) of questions for which the answer is

1. Has a doctor ever denied or restricted your participation in sports for any reason or told you to give up sports?.....	Y	N
2. Do you have an ongoing medical condition (like diabetes or asthma)?	Y	N
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	Y	N
List: _____		
4. Do you have allergies to medicines, pollens, foods, or stinging insects?.....	Y	N
5. Have you ever passed out or nearly passed out DURING exercise?	Y	N
6. Have you ever passed out or nearly passed out AFTER exercise?.....	Y	N
7. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	Y	N
8. Does your heart race or skip beats during exercise?	Y	N
9. Has a doctor ever told you that you have? (circle): High blood pressure A heart murmur High cholesterol A heart infection Rheumatic fever		
10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram, stress test)	Y	N
11. Has anyone in your family died suddenly and unexpectedly for no apparent reason?	Y	N
12. Does anyone in your family have a heart problem?	Y	N
13. Has any family member or relative died of heart problems or of sudden death before age 50?.....	Y	N
14. Has anyone in your family less than 50 years old had unexplained drowning while swimming or an unexplained car accident?	Y	N
15. Does anyone in your family have Marfan syndrome?.....	Y	N
16. Have you ever spent the night in a hospital?	Y	N
17. Have you ever had surgery?.....	Y	N
18. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game?	Y	N
19. Have you had any broken or fractured bones, or dislocated joints?	Y	N
20. Have you had a bone/joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? Y / N		
If Yes in Questions 18, 19 or 20, please circle the area below:		
Head Neck Shoulder Chest Upper Arm Elbow Forearm Hand/Fingers Upper Back Lower Back Hip Thigh Knee Calf/Shin Ankle		
Foot/Toes		
21. Have you ever had a stress fracture?	Y	N
22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?.....	Y	N
23. Do you regularly use a brace or assistive device?	Y	N
24. Has a doctor ever told you that you have asthma or allergies?	Y	N
25. Do you cough, wheeze, chest tightness, or have difficulty breathing during or after exercise?	Y	N
26. Is there anyone in your family who has asthma?	Y	N
27. Have you ever used an inhaler or taken asthma medicine?	Y	N
28. Do you develop a rash or hives when you exercise?	Y	N
29. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	Y	N
30. Have you had infectious mononucleosis (mono) within the last month?	Y	N
31. Do you have any rashes, pressure sores, or other skin problems?	Y	N
32. Have you had a herpes skin infection?	Y	N
33. Have you ever had a head injury or concussion?.....	Y	N
34. Have you been hit in the head and been confused or lost your memory?	Y	N
35. Have you ever had a seizure?	Y	N
36. Do you have headaches with exercise?.....	Y	N
37. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	Y	N
38. Have you ever been unable to move your arms or legs after being hit or falling?	Y	N
39. When exercising in the heat, do you have severe muscle cramps or become ill?	Y	N
40. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	Y	N
41. Have you had any problems with your eyes or vision?.....	Y	N
42. Do you wear glasses or contact lenses?.....	Y	N
43. Do you wear protective eyewear, such as goggles or a face shield?.....	Y	N
44. Are you happy with your weight?	Y	N
45. Are you trying to gain or lose weight?	Y	N
46. Has anyone recommended you change your weight or eating habits?.....	Y	N
47. Do you limit or carefully control what you eat?	Y	N
48. Do you get tired more quickly than your friends do during exercise?.....	Y	N
49. Do you have any concerns that you would like to discuss with a doctor?	Y	N
FEMALES ONLY		
50. Have you ever had a menstrual period?	Y	N
51. How old were you when you had your first menstrual period? _____		
52. How many menstrual periods have you had in the last year? _____		

Notes: _____

I do not know of any existing physical or additional health reason that would preclude participation in dance. I certify that the answers to the above questions are true and accurate and I approve participation in dance activities.

Parent or Legal Guardian Signature

Student Signature

Date

Kansas City Friends of Alvin Ailey

Student Name: _____ Birth Date: _____ Age: _____ Gender: M / F

Follow-Up Questions About More Sensitive Issues:

1. Do you feel stressed out or under a lot of pressure?
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?
3. Do you feel safe?
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?
5. During the past 30 days, did you use chewing tobacco, snuff, or dip?
6. During the past 30 days, have you had at least 1 drink of alcohol?
7. Have you ever taken steroid pills or shots without a doctor's prescription?
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?
9. Question "Risk Behaviors" like guns, seatbelts, unprotected sex, domestic violence, drugs, and others.

Notes About Follow-Up Questions:

MEDICAL EXAM

Height _____ Weight _____ BMI (optional) _____ % Body fat (optional) _____ Arm Span _____
 Pulse _____ BP _____ / _____ (_____ / _____)
 Vision: R 20/____ L 20/____ Corrected: Y / N Contacts: Y / N Hearing: R ____ L ____ (Audiogram or confrontation)

Exam	Normal	Abnormal Notes	Initials*
Appearance	Y / N		
HEENT	Y / N		
Eyes	Y / N		
Fundoscopic	Y / N		
Pupils	Equal / Unequal		
Ears/Nose	Y / N		
Hearing	Y / N		
Throat	Y / N		
Dental	Y / N		
Lymph Nodes	Y / N		
Thyroid	Y / N		
Heart	Y / N		
Murmurs	Y / N		
Pulses	Y / N		
Lungs	Y / N		
Abdomen	Y / N		
Genitourinary (Male)	Y / N		
Hernia	Y / N		
Tanner Staging (optional)	I II III IV V		
Skin	Y / N		
Musculoskeletal			
Neck	Y / N		
Back	Y / N		
Shoulder/Arm	Y / N		
Elbow/Forearm	Y / N		
Wrist/Hand/Fingers	Y / N		
Hip/Thigh	Y / N		
Knee	Y / N		
Leg/Ankle	Y / N		
Foot/Toes	Y / N		
Duck Walk	Y / N		

* Required Only if Multiple Examiners

Notes:

Assessment:

Immunizations: Up-to-Date

Health maintenance:

Discussed Lead and TB exposure – (Testing indicated / not indicated)

Plan:

Immunize if needed (Required by age 12 or entry to 7th grade: DTaP series plus tD with Pertusis, 4 HIB, 2MMR, 3 HBV, 4 IPV)

Consider Flu Shot (Asthma, winter athletes)

Lifestyle, health, and safety counseling

Discussed dental care and mouthguard use