



For Office Use Only
Date Received: _____
Date Approved: _____
Approved By: _____
Date Begin Program: _____

ENRICHMENT CENTER PROGRAMS

11107 Wurzbach Road, Ste 203
San Antonio, TX 78230
210.694.9090

Date: _____

APPLICANT INFORMATION

Applicant's Name: _____ Date of Birth: _____

Applicant's Home Address: (Street) _____

(City): _____ (State): _____ (Zip): _____

Race: ___ Caucasian ___ Hispanic ___ African-American ___ Asian ___ Other

Via ID #: _____

Program Applying For (please circle all that apply): After School Summer Session 1 Summer Session 2

Applicant attends:

School District: _____ School: _____

Teacher(s): _____ School Phone #: _____

I, _____ give permission for Eva's Heroes to contact _____ (applicant's teacher) about programmatic needs while reviewing application and while attending Eva's Heroes Enrichment Program.

Parent/Guardian Signature

Date

FAMILY CONTACT INFORMATION

Mother's Name: _____ Home Phone: _____

E-mail Address: _____ Cell Phone: _____

Mother's Place of Work: _____ Work Phone: _____

Mother's Home Address: (if different from applicant) _____

(City): _____ (State): _____ (Zip): _____

Father's Name: _____ Home Phone: _____

E-mail Address: _____ Cell Phone: _____

Father's Place of Work: _____ Work Phone: _____

Father's Home Address: (if different from applicant) _____

(City): _____ (State): _____ (Zip): _____

Applicant Lives With **(Circle One)**: Mother Father Both Parents Other _____

GUARDIAN CONTACT INFORMATION

Guardian's Name: _____ Home Phone: _____

E-mail Address: _____ Cell Phone: _____

Guardian's Place of Work: _____ Work Phone: _____

Guardian's Home Address: (if different from applicant) _____

(City): _____ (State): _____ (Zip): _____

Type of Guardianship: _____

Is the student his or her own guardian: ____ YES ____ NO (If YES, continue below)

PHYSICIAN CONTACT INFORMATION

Name of Physician: _____

Office Address(Street): _____

(City): _____ (State): _____ (Zip): _____

Office Phone #: _____ Contact Person: _____

MEDICAL / PHYSICAL INFORMATION

Primary Diagnosis: _____

Other Medical Diagnosis:

Hospital Preference: _____

Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____

Identifying Marks/Scars: _____

CURRENT MEDICATION REGIMEN

Please include all medication prescribed:

Medication: _____ Dosage/Schedule: _____

Reason Taken: _____

Medication: _____ Dosage/Schedule: _____

Reason Taken: _____

Medication: _____ Dosage/Schedule: _____

Reason Taken: _____

Medication: _____ Dosage/Schedule: _____

Reason Taken: _____

Medication: _____ Dosage/Schedule: _____

Reason Taken: _____

LIKES / DISLIKES

Please list specific likes and dislikes that the applicant may have: (i.e. dislikes large crowds, likes water activities)

LIKES	DISLIKES

Please write yes or no for each question:

Is the applicant toilet trained? _____

Is the applicant on a toileting schedule? _____ If yes, please describe: _____

Does the applicant need diapering? _____

Is the applicant ambulatory? (walk independently) _____

Does the applicant use a walker? _____

Does the applicant use a wheelchair? _____

Does the applicant use a gait belt? _____

Does the applicant eat independently? _____

Does the applicant require assistance during meals? _____ If yes, please describe specific needs:

What is the applicant's primary means of communication? (verbal, pictures, gestures, sign language, etc.)

Please provide specific information: _____

Does the applicant have any allergies: _____ If yes, please indicate allergies and type of reaction:

Does the applicant have seizures? _____ If yes, what is the frequency and duration of seizures?

Does the applicant have any special health care or dietary needs? _____ YES _____ NO

If yes, please indicate: _____

Other pertinent information (i.e. existing illness, injuries, hospitalizations within the past 12 months, special instructions:)

EMERGENCY CONTACT INFORMATION

NAME OF PERSON TO CALL IN CASE OF EMERGENCY IF PARENT(S)/GUARDIAN(S) CAN NOT BE REACHED.

Name: _____ Relationship to Applicant: _____
Home Phone: _____ Cell Phone: _____
Place of Work: _____ Work Phone: _____
Address (Street): _____
(City): _____ (State): _____ (Zip): _____
Driver's License #: _____

Name: _____ Relationship to Applicant: _____
Home Phone: _____ Cell Phone: _____
Place of Work: _____ Work Phone: _____
Address (Street): _____
(City): _____ (State): _____ (Zip): _____
Driver's License #: _____

Eva's Heroes does not assume any financial responsibility but does wish to provide the best emergency service. By signing this form you are giving the appropriate Eva's Heroes personnel authority to call the EMS or obtain medical care if you or the alternate adults listed as emergency contacts cannot be reached.

Signature of Parent or Guardian **Date**

In addition to the emergency contacts listed above, I give permission to the following persons to pick up the applicant from Eva's Heroes:

Name: _____ Relationship to Applicant: _____
Home Phone: _____ Cell Phone: _____
Driver's License #: _____

Name: _____ Relationship to Applicant: _____
Home Phone: _____ Cell Phone: _____
Driver's License #: _____

Name: _____ Relationship to Applicant: _____
Home Phone: _____ Cell Phone: _____
Driver's License #: _____

REGISTRATION APPLICATION CHECKLIST:

The following must be provided before your application will be reviewed for enrollment and attendance. If the item does not apply, mark the space N/A.

- _____ Completed Registration Forms
- _____ Current Photograph
- _____ \$25.00 Registration Fee
- _____ Copy of Most Recent IEP
- _____ Copy of Most Recent Behavior Management Plan (If Applicable)
- _____ Copy of Via Transportation Card (If Applicable)
- _____ Copy of Guardianship Papers (If Applicable)
- _____ Physician's Orders for Current Medications

PERMISSIONS SIGNATURES

Medical Permissions

In the event that I cannot be reached to authorize medical attention for _____, I authorize a representative of the Eva's Heroes Enrichment Center ("EHEC") to seek medical attention and grant medical staff permission to treat my child. I, for myself, my heirs, executors, administrators, trustees, and any and all successors in interest, hereby WAIVE AND RELEASE EVA'S HEROES (including without limitation, its directors, officers, administrators, employees, agents, assigns, and representatives) from all liability or claims, including without limitation, for any property loss, damage, injury or death resulting, whether directly or indirectly, from injury incurred by my child during EHEC activities.

_____ **Date**

Parent's/Guardian's Signature

Photo Release

I understand and agree that Eva's Heroes Enrichment Center ("EHRC") may take and utilize photos and videos of the field trip/activity for the limited purpose of portraying and/or promoting EHEC activities and I hereby grant EHEC non-compensable use of my child's image or likeness for this limited purpose.

_____ **Date**

Parent's/Guardian's Signature

Transportation Permission

The Eva's Heroes Enrichment staff has my permission to transport my child to and from the center or agreed upon location on excursions or other planned field trips. I understand that participation in the field trip/activity involves inherent risk and I expressly and voluntarily assume all risk of property loss, damage, injury or death sustained while participating in the field trip/activity.

_____ **Date**

Parent's/Guardian's Signature

