



CLCP Student Registration Form

2004 – 2005

The Computer Learning Centers Partnership (CLCP), operated by the Fairfax County Office of Partnerships (OOP), is an afterschool program which provides technology access and training to assure digital equity and increase overall literacy for underserved children. Enrichment activities are incorporated to ensure the development of the whole child.

Children who have completed Kindergarten through those enrolled in twelfth grade, who are residents of Fairfax County and who live in the service areas are eligible to attend the program.

Policies and Procedures

1. Participation: The coming and going of participants are the responsibility of the parents. Should a child leave the center for any reason, he/she will no longer be the responsibility of OOP/CLCP.
2. Medical: I authorize Fairfax County to obtain immediate medical care at my expense if any emergency occurs when I cannot be located immediately.
3. Schools: I agree that the Fairfax County Office of Partnerships, through its Computer Learning Centers Partnership (CLCP) Center staff, may communicate with Fairfax County Public Schools staff regarding my child's performance records and progress. This includes, but is not limited to, access to report cards and test scores.
4. Photo Release: I give permission to Fairfax County, through its Office of Partnerships to allow quotes and/or images of my minor child to be used by the media, to include internet, radio, newspaper and television, in reporting on programs sponsored by the Office of Partnerships.
5. Behavioral Issues: If the actions of a participant cause injury to other participants or staff, CLCP reserves the right to deny his/her continuation in the program. If property is destroyed or damaged, parents or guardians may be required to pay for repairs. Parents and children must sign the "Rules of Conduct" before a child may enter the program. All participants enrolled must be able to demonstrate the following with minimal redirection: (1) participant must be able to maintain personal care without the support of CLCP staff/volunteers, (2) participant must be able to stay with his/her assigned group, and (3) participant must respect others and maintain self control at all times (keeping hands/feet to self, anger management, follow directions, use appropriate language).
6. Permissions: I hereby grant permission for my child to participate in all activities, programs, special events, and walking/bus trips sponsored by OOP/CLCP.
7. Liability: I agree that Fairfax County, the Board of Supervisors of Fairfax County and the members thereof, the Fairfax County Office of Partnerships and its CLCP Centers, and the officers, agents, employees and volunteers of the said Fairfax County, Board of Supervisors, Office of Partnerships, and CLCP Centers, in their official and in their individual capacities, shall have no liability for and are hereby expressly released and discharged from any and all liability for any loss, injury or damages to persons or property that may be sustained by reason of my child's participation in any and all activities sponsored by Fairfax County, the Office of Partnerships, or the CLCP Centers, whether such liability is based in contract, tort (including negligence), strict liability or otherwise.

Participant's information (Please use a separate form for each child)

Child's First Name:		Child's Last Name:	
Address:		City, State, Zip Code:	
Home Phone:		Nickname:	
Language spoken at home:		Birth Date:	
Name of School:	Grade in Fall:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Age:
Allergies/Medical Concerns: <input type="checkbox"/> bee stings <input type="checkbox"/> insect bites <input type="checkbox"/> foods <input type="checkbox"/> Other explain: _____ What should be done if your child comes in contact with an allergen? _____ Please tell us if your child has any health problems we should know about: _____			
Mother's Name:		Father's Name:	
Mother's Work Number:		Father's Work Number:	
Emergency Contact:		Phone Number:	
Doctor's name and phone number:		Health Insurance Co. and Policy No.:	
Do you have computer at home? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have Internet access? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Ethnicity (information collected for informational purposes only) <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> 2 or more races <input type="checkbox"/> White (Non-hispanic) <input type="checkbox"/> Hispanic (all races)			
Income (information collected for informational purposes only) <input type="checkbox"/> \$40,000 or higher <input type="checkbox"/> \$28,000-\$39,999 <input type="checkbox"/> \$17,000-\$27,999 <input type="checkbox"/> \$16,999 or lower			
I certify that I have read and understand all policies and procedures as outlined.			
Signature of Parent/Guardian		Date	