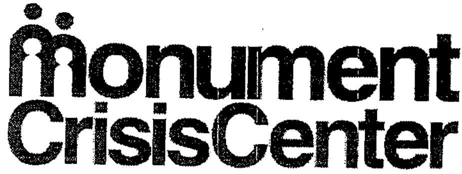


Address: 1990 Market St. Concord, CA 94520
Mailing address: P. O. Box 23973. Pleasant Hill, CA 94523
Phone: 925.825.7751 | fax: 925.825.8732

Office Use Only

Date Completed: ____________

Received By: ____________

TUTOR APPLICATION

After School Café Application

Circle one:

Day Tutoring: Wednesday or Thursday

Email address: ____________________________________

Name ____
Last First M.I.

Address ____

Birthdate ____/____/______ Age _____ Grade _____ School ____________________

Allergy Alert: Does your child have allergies? YES ____ No ____ EpiPen? _______ list details on back of form

Parent (s) or Guardian (s) Contact Information

Name ______________________________ Relationship ____________________

Home Address ____

Phone # 1. (h / c / w)________________ # 2.(h / c / w)________________

Name ______________________________ Relationship ____________________

Home Address ____

Phone # 1. (h / c / w)________________ # 2.(h / c / w)________________

In the event of an emergency, we always try to contact parents first. However, we are <u>required</u> to have an emergency contact <u>OTHER THAN</u> parents/guardians. These people are also <u>authorized to pick up your child</u> from the facility. Please list all appropriate phone numbers.

Name ______________________________ Relationship ____________________

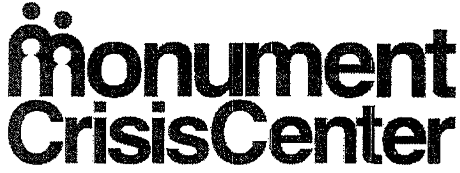
Phone ______________/______________/______________/______________

Name ______________________________ Relationship ____________________

Phone ______________/______________/______________/______________

Please Note:

Your child will not be released to anyone who is NOT on this list. Persons on this list will be asked to present identification at time of pick-up. Please notify Monument Crisis Center if there is a person who is not, under any circumstances, authorized to pick up your child.



Address: 1990 Market St. Concord, CA 94520
Mailing address: P. O. Box 23973. Pleasant Hill, CA 94523
Phone: 925.825.7751 | fax: 925.825.8732

Insurance and Medical Information:

Insurance Provider ____________________ ID Number __________________________

Medical Provider __________________________ Phone __________________________

Does your child require any medication while at the program? ☐ Yes (please list) ☐ No

____

Allergies – Does your child have any allergies to food, medications, insects, etc.? ☐ Yes ☐No

If Yes, please list: ____

Health Conditions – Has your child, currently or in the past, been diagnosed with any of the following health conditions (check all that apply):

Asthma	☐ Yes	☐ No	Epilepsy/Seizure Disorder	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Frequent Migraine Headaches	☐Yes	☐ No
Heart Problems	☐ Yes	☐ No	Attention Deficit-Hyperactivity	☐ Yes	☐ No
Vision/Hearing Problems	☐ Yes	☐ No	Chronic Ear Infections	☐Yes	☐ No

If Yes, please explain: ____

List any other health condition(s) not listed above: ______________________________________

____

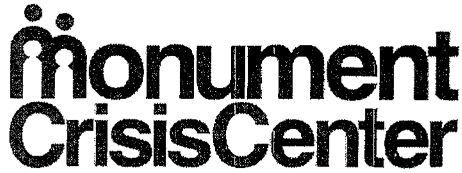
____

Please list any other information that will assist our staff in helping your child during the program.

____

____

Print Full Name of Parent, Guardian ____________________ Signature ____________________ Date ____________



ASC Tutor Behavior Contract Fall 2016

Please read and initial on the provided line.

- I WILL COMMIT MYSELF TO BECOMING A CONCERNED AND INVOLVED TUTOR ________
- I WILL MAINTAIN A COOPERATIVE RELATIONSIHP WITH MY STUDENTS ________
- I WILL ATTEND AND ACTIVELY PARTICPATE IN ONE OF THE TUTOR TRANINGS ________
- I WILL NOT MISS MORE THAN THREE(3) TUTORING DAYS ________
- I WILL BE PROMPT FOR ALL SESSIONS WITH MY ASSIGNED STUDENTS ________
- I WILL BEHAVE IN A PROFESSIONAL MANNER AT ALL TIMES AND KEEP IN CONTACT WITH CENTER STAFF REGARDING MY RESPONSIBILITES ________
- I WILL NOTIFY THE SUPERVISORY STAFF OF ANY INNAPROPRIATE BEHAVIOR INVOLVING ________ THE STUDENTS, TUTORS, OR STAFF
- I WILL NOT USE MY PHONE DURING TUTORING ________
- I UNDERSTAND THAT IF I WISH TO USE MY VOLUNTEER HOURS FOR SCHOOL RELATED PURPOSES (ex. NHS, confirmation, scouting, class project) I MUST FIRST HAVE THE WRITTEN PERMISSION OF THE ASC COORDINATOR ________
- I UNDERSTAND THAT I MAY **NOT** USE MY VOLUNTEER HOURS FOR COURT MANDATED HOURS. **NO EXCEPTIONS** ________
- I WILL FILL OUT ALL DOCUMENTS NEEDED AND PROVIDE ALL NECESSARY INFORMATION AND KEEP SAFETY AT AL LTIMES AS MY TOP PRORITY ________
- I WILL NOTIFY ASC COORDINATOR BY EMAIL afterschoolcafe2350@gmail.com OR BY PHONE IF I AM UNABLE TO MAKE IT TO ANY TUTORING SESSION **(925) 825-7751 ext 126** ________

Print Name: ____________________

Tutor Signature: ____________________ Date: ____________________

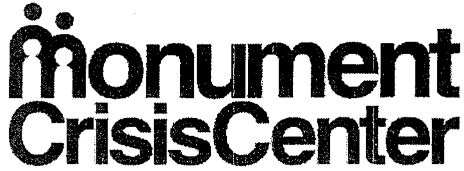
Phone Number: ____________________

Email address: ____________________

I have reviewed the After School Café contract with my child and understand it.

Parent Signature: ____________________

** If you need court order service hours please speak to After School Café Coordinator for a referral to an alternate Monument Crisis Center program



Address: 1990 Market St. Concord, CA 94520
Mailing address: P. O. Box 23973. Pleasant Hill, CA 94523
Phone: 925.825.7751 | fax: 925.825.8732

Please list any restrictions to photo release form

☐ I grant the Monument Crisis Center the right to take photographs and video of my child while at the Center. I authorize the Monument Crisis Center, as well as its assignees and transferees to copyright, use and publish the same in print and/or electronically. I agree that the Monument Crisis Center may use such photographs with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and web content.

☐ I **DO NOT** grant the Monument Crisis Center the right to take photographs and video of my child while at the Center.

Restrictions: ______________________________

Print Full Name of Parent, Guardian	Signature	Date

My Signature gives permission for the following:

Emergency Release

If, in the judgment of the staff of the Monument Crisis Center the child named above needs immediate care and treatment as a result of any injury or sickness, I hereby give permission to the staff to secure proper treatment for my child. I do hereby consent to whatever x-ray, examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care are considered necessary in the best judgment of the attending physician, surgeon or dentist and performed by or under the supervision of the medical staff of the hospital or facility furnishing medical or dental services. It is further understood that the undersigned will assume full responsibility for any such action, including payment of costs. I do hereby agree to indemnify and hold harmless the Monument Crisis Center (including its officers, directors, members and/or volunteers) from any claim by any person whomsoever on account of such care and treatment of said child.

Print Full Name of Parent, Guardian	Signature	Date