PASSIONATE ABOUT LEARNING

P.A.L. PROGRAM

Volunteer Action Center

WASHINGTON ELEMENTARY

Grades 2,3,4

Students must have completed and returned all consent forms to the school office before participating in the program. If you have any questions, you may contact us at **vacpal@uark.edu** or call the Center for Community Engagement at **479-575-4365.**

Print student's first and last name

_____ has my permission to participate in the VAC P.A.L.Program that will take place Monday- Thursday after school 3:00-4:15 pm during the Fall 2018 semester from the week of **September 17th through December 6th.** I also grant the University of Arkansas, its representatives and employees the right to take photographs and video of this individual in connection with the VAC P.A.L.Program. I authorize the University of Arkansas to use and publish the same in print and/or electronically for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content. I give permission for Washington Elementary School to release pertinent information from the student's education record to VAC P.A.L.Program.

_____ _____

Parent/Guardian Name (Print) ***Date***

_____ _____

Parent/Guardian Signature ***Date***

Parent Phone Number

(_____)_____

Parent Contact Email (print please)

_____

Student's grade level: _____

Days of Participation

*Mark with an **X** the day or days you wish your student to participate.*
Students may participate every day.

_____ Monday _____ Wednesday

_____ Tuesday _____ Thursday

After the Program

How will your child get home? Please mark the appropriate choice and explain if necessary.

_____ Parent/Guardian Pick-Up

_____ SKC Program

_____ Bus*

* If you marked the BUS option for your student, please list your **address below**, and remember that you must be on **the regular Washington bus route** in order to access the late bus.

_____

_____

_____

Emergency Contact

Name _____

Phone Number (_____)_____

Relationship _____

Please <u>list the names</u> of others who can up pick this child from the Volunteer Action Center (VAC) P.A.L. Program. I UNDERSTAND THAT THE NAMES LISTED ARE THE ONLY PEOPLE WHO WILL BE ALLOWED TO PICK UP THIS CHILD FROM OUR AFTERSCHOOL PROGRAM. This is to ensure the safety of all participants.

Name(s)_____

_____

PLEASE PRINT NAME(S) LEGIBLY

Allergies & Special Circumstances

Please list any food allergies that your child has and note specific snacks he/she is not able to eat. Explain any other special circumstances that the VAC P.A.L.Program should know about.

Allergy: _____

Other notes:

_____

Consent to share relevant information

I understand that by signing this section of the permission slip I authorize the school and VAC P.A.L.Program to share relevant information about my student.

_____ _____

Parent/Guardian Name (Signature) ***Date***