COMMON GRACE'S MENTORING PROGRAM PARENTAL CONSENT FORM **(For Elementary School Student)**

School: _____ Grade: _____

(All information provided will be kept in a confidential file in our office. Please print clearly!)

PERSONAL INFORMATION

Child Last Name: _____ Child First Name: _____

Child Gender: ☐Male ☐Female Child Age: _____ Homeroom Teacher: _____

Child Ethnicity:
☐ Japanese ☐ Chinese ☐ Filipino ☐ Vietnamese ☐ White ☐ Black or African American

☐ Micronesian ☐ Polynesian ☐ Hispanic/Latino ☐ Native Hawaiian ☐ Other: _____

GUARDIAN INFORMATION

Guardian Last Name: _____ Guardian First Name: _____

Relationship to Child: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Email: _____

Street Address: _____

Do you give the Mālama Mentors team consent to send you text messages?
Please circle --> Yes No

IN CASE OF EMERGENCY

In case of emergency, if the adult listed above cannot be contacted, please call:

Name: _____ Phone: _____

Relationship to Child: _____

CONSENT

I consent for my child:

- To participate in the Common Grace Program—spending an hour a week with a trained high school Common Grace mentor, in which my child will participate in speaking, reading, and indoor/outdoor play activities.
- To be filmed and/or photographed by Common Grace staff for Common Grace promotional materials. The child will not be named or otherwise identified in the use of these videos/pictures.

_____

Parent/Guardian Name (Please Print) Parent/Guardian Signature Date

MEDIA RELEASE

I,_____, hereby give permission for Common Grace to use recorded film, still images, or audio of my child in promotional materials to further the program at other schools.

_____ _____

Parent/Guardian Initials Date

CONFIDENTIAL MEDICAL INFORMATION

In case of medical or dental emergency, I understand that every effort will be made to contact me. If unable to contact me, contact the individual designated above. If unable to contact me, or the designated individual, I hereby give permission to the above-mentioned volunteer mentor to secure treatment for my child from the physician/medical facility indicated below. If unable to secure medical-related services from the indicated physician/medical facility, I authorize the volunteer mentor to secure treatment from another physician/medical facility. As the parent or legal guardian, I will assume all costs for medical-related services rendered on behalf of my child.

Child's Medical Insurance Carrier: _____ ☐ None

Child's Physician/Medical Facility: _____ Phone: _____

_____

Parent or Legal Guardian's name (print):

_____

Parent or Legal Guardian's name (signature):

After the Mentoring Hour, do you wish your child to be ...

A. _____ Walk home alone, walk home with mentor, or walk home with (list all persons walking with your child): _____

B. _____ My child will be picked up by _____ at the room _____. This person must be on time and responsible.

Name of Person _____

Phone Number (Must be current and working phone number)

_____

C. _____ My child is enrolled in After School All-Stars. Everyday (Monday thru Friday), my child is picked up from _____ at this time _____.

If you are picking up your child earlier than the time you listed above, on the day your child is scheduled for Common Grace mentoring session, you <u>MUST</u> notify or leave a message to your child's coordinator.

_____	_____	_____
Coordinator	**Email**	**Phone Number**

<u>PLEASE SUBMIT ENTIRE FINISHED PACKET TO THE SCHOOL'S COUNSELOR/TEACHER</u>