

FAITH TABERNACLE MISSIONARY BAPTIST CHURCH



MARK OF EXCELLENCE

# AFTER SCHOOL & TUTORING PROGRAM

LEARN, EXPLORE & GROW



GRADES  
K-5

**WHAT WE OFFER:**

- HOMEWORK HELP
- MATH & READING TUTORING
- EXCELLENT TEACHERS
- TECHNOLOGY/CODING
- MUSIC FINE ARTS
- SPORTS
- TRANSPORTATION PROVIDED

MONDAY-FRIDAY 3:00-6:00

**\$250**  
Per  
Month

29 GROVE STREET, STAMFORD, CT 06901 | (203)353-1503 | [WWW.MARKOFEXCELLENCEPA.ORG](http://WWW.MARKOFEXCELLENCEPA.ORG)



**Mark of Excellence**



29 GROVE STREET  
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203-353-1503  
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## **AFTERSCHOOL PROGRAM REGISTRATION BOOKLET**

**DR. JOSEPH FORD  
EXECUTIVE DIRECTOR**

**PHYLLIS T. CRAIG  
DIRECTOR**

**WELCOME TO EXCELLENCE**

Mark of Excellence



I WILL BE REGISTERING MY CHILD/CHILDREN FOR THE MARK OF EXCELLENCE AFTER SCHOOL PROGRAM FOR THE UPCOMING SCHOOL YEAR. ENCLOSED IS MY \$50.00 NON-REFUNDABLE REGISTRATION FEE PER CHILD TO RESERVE SPACE IN THE PROGRAM FOR THE 2024-2025 SCHOOL YEAR.

CHILD'S NAME: \_\_\_\_\_ GRADE: \_\_\_\_\_

SCHOOL: \_\_\_\_\_

CHILD'S NAME: \_\_\_\_\_ GRADE: \_\_\_\_\_

SCHOOL: \_\_\_\_\_

CHILD'S NAME: \_\_\_\_\_ GRADE: \_\_\_\_\_

SCHOOL: \_\_\_\_\_

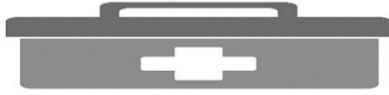
PARENT/GUARDIAN: \_\_\_\_\_

EMAIL: \_\_\_\_\_

PHONE: \_\_\_\_\_

FOR OFFICE USE ONLY
DATE
AMOUNT
CHECK #
CASH RECEIPT #
PAYMENT

**MARK OF EXCELLENCE AFTERSCHOOL EMERGENCY INFORMATION**  
(Please Print)



CHILD'S NAME \_\_\_\_\_

BIRTHDAY: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

MOTHER'S NAME: \_\_\_\_\_

FATHER'S NAME: \_\_\_\_\_

**CONTACT INFORMATION**

MOTHER:

HOME \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

FATHER:

HOME \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

E-MAIL \_\_\_\_\_

**ALTERNATE EMERGENCY CONTACT PERSON (S)**

NAME: \_\_\_\_\_ PHONE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

NAME: \_\_\_\_\_ PHONE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

**MEDICAL INFORMATION (ALLERGIES TO MEDICATIONS, FOODS, OTHER SUBSTANCES, ETC)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HOSPITAL PREFERENCE \_\_\_\_\_

CHILDS DOCTOR \_\_\_\_\_

I agree that the operator may authorize the physician of his/her choice to provide emergency medical care in the event that neither I, my spouse, alternate contact(s) nor my child's doctor can be located immediately.

Parent's Signature: \_\_\_\_\_ Date \_\_\_\_\_

Operator's Signature: \_\_\_\_\_ Date \_\_\_\_\_



## MARK OF EXCELLENCE AFTERSCHOOL PROGRAM

WE WILL NOT BE RESPONSIBLE FOR FALSE INFORMATION  
PLEASE FILL OUT THIS FORM COMPLETELY.  
MAKE SURE ALL INFORMATION IS CORRECT.

THIS FORM IS TAKEN WITH STAFF MEMBERS WHENEVER THE CHILD LEAVES  
THE CENTER ON FIELD TRIPS, PLAYGROUND ETC.

CHILD'S NAME: \_\_\_\_\_ AGE \_\_\_\_\_ DOB \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PHONE NUMBER: \_\_\_\_\_ CELL \_\_\_\_\_

MOTHERS WORK NO. & ADDRESS: \_\_\_\_\_

FATHERS WORK NO. & ADDRESS: \_\_\_\_\_

EMERGENCY CONTACT PERSONS (2) PERSON SHOULD BE ABLE TO ACT ON  
YOUR BEHALF IT YOU CANNOT BE REACHED.

NAME: \_\_\_\_\_ PHONE NO. \_\_\_\_\_  
CELL NO. \_\_\_\_\_

ADDRESS: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

NAME: \_\_\_\_\_ PHONE NO. \_\_\_\_\_  
CELL NO. \_\_\_\_\_

ADDRESS: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ANY KNOWN ALLERGIES \_\_\_\_\_  
IS CHILD ON REGULAR MEDICATION? \_\_\_\_\_

HOSPITAL PREFERENCE \_\_\_\_\_

CHILD'S DOCTOR: \_\_\_\_\_ PHONE \_\_\_\_\_  
ADDRESS: \_\_\_\_\_

I AGREE THAT THE OPERATOR/STAFF MAY TAKE MY CHILD TO THE EMERGENCY  
ROOM FOR CARE IN THE EVENT THAT I CAN NOT BE CONTACTED.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_



# MARK OF EXCELLENCE AFTERSCHOOL PROGRAM

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PLEASE FILL OUT THIS APPLICATION COMPLETELY. ACCURATE INFORMATION IS NECESSARY SO THAT WE MAY BEST SERVE YOUR CHILD. IT IS YOUR RESPONSIBILITY TO NOTIFY US IMMEDIATELY OF ANY CHANGES.

DATE \_\_\_\_\_ (START DATE \_\_\_\_\_)

CHILD'S NAME \_\_\_\_\_

DOB \_\_\_\_\_ NICKNAME \_\_\_\_\_

NUMBER OF DAYS OF ATTENDANCE: \_\_\_\_\_

CIRCLE DAYS OF ATTENDANCE: MON. TUES. WED. THURS. FRI.

NAME OF ELEMENTARY SCHOOL: \_\_\_\_\_

GRADE: \_\_\_\_\_

PHONE NO. \_\_\_\_\_ E-MAIL \_\_\_\_\_

HOURS CARE IS NEEDED \_\_\_\_\_

WHO IS CHILD'S LEGAL GUARDIAN? \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_

FATHERS NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

CITY \_\_\_\_\_ ZIP \_\_\_\_\_

MOTHERS' EMPLOYER & ADDRESS \_\_\_\_\_

MOTHER'S WORK NUMBER \_\_\_\_\_ CELL NO. \_\_\_\_\_

FATHER'S EMPLOYER & ADDRESS \_\_\_\_\_  
\_\_\_\_\_

FATHERS WORK NUMBER \_\_\_\_\_ CELL NO. \_\_\_\_\_

**MEMBERS OF HOUSEHOLD & RELATIONSHIPS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**WHO IS AUTHORIZED TO PICK YOUR CHILD UP FROM SCHOOL?**

\_\_\_\_\_  
\_\_\_\_\_

DOES CHILD SPEAK ANY OTHER LANGUAGE? \_\_\_\_\_?

IS THERE ANY FOODS YOUR CHILD CAN NOT EAT \_\_\_\_\_?

IS THERE ANYTHING WE CAN DO TO MAKE YOUR CHILD'S STAY HERE MORE ENJOYABLE? \_\_\_\_\_  
\_\_\_\_\_

IS THERE A PROBLEM WITH YOUR CHILD THAT WE SHOULD BE AWARE OF?  
\_\_\_\_\_

PLEASE BE AWARE THAT AT ANY TIME YOU MAY BE ASKED TO REMOVE YOUR CHILD IF HE OR SHE CONTINUES TO CAUSE HARM TO HIMSELF OR OTHER CHILDREN WITHOUT NOTICE.

PARENTS SIGNATURES \_\_\_\_\_ DATE \_\_\_\_\_  
\_\_\_\_\_ DATE \_\_\_\_\_

## CHILDS MEDICAL HISTORY

NAME \_\_\_\_\_

	YES	NO	AGE	DESCRIBE OR COMMENT
HAVE YOUR CHILD HAD				
MEASLES				
GERMAN MEASLES				
MUMPS				
CHICKEN POX				
WHOOPING COUGH				
DPHITHERIA				
IFLUENZA (FLU)				
MENINGITIS				
HIGH FEVERS				
ABSCESED EARS				
ENCEPHALITIS				
ALLERGY				
CONVULSIONS				
INJURIES TO HEAD				
LEAD POISONING				
ANEMIA				
HOSPITALIZATIONS				
OPERATIONS				
OTHER INJURIES				





**PERMISSION AGREEMENT**

**A. I/WE GRANT PERMISSION FOR MY CHILD TO PARTICIPATE IN ALL OF THE ACTIVITIES OF THE SCHOOL, UNLESS EXCEPTIONS ARE NOTED HERE:**

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**B. I/WE GRANT PERMISSION FOR MY CHILD TO LEAVE THE SCHOOL PREMISES UNDER THE SUPERVISION OF A STAFF MEMBER FOR NEIGHBORHOOD WALKS OR ON FIELD TRIPS IN AN AUTHORIZED VEHICLE.**

**C. I/WE GRANT PERMISSION FOR MY CHILD TO BE INCLUDED IN EVALUATIONS AND CONNECTED WITH THE AFTERSCHOOL PROGRAMS.**

**D. I HEREBY GRANT PERMISSION FOR THE STAFF TO TAKE WHATEVER STEPS MAY BE NECESSARY TO OBTAIN EMERGENCY MEDICAL CARE IF WARRANTED. THESE STEPS MAY INCLUDE, BUT ARE NOT LIMITED TO THE FOLLOWING:**

**1. ADMINISTER FIRST AID.**

**2. ATTEMPT TO CONTACT PARENT OR GUARDIAN.**

**3. ATTEMPT TO CONTACT THE CHILD'S PHYSICIAN.**

**4. ATTEMPT TO CONTACT THE PARENT THROUGH ANY OF THE PERSONS LISTED ON THE EMERGENCY INFORMATION PAPER COMPLETED FOR THE CENTER. (NOTE IT IS THE PARENT'S RESPONSIBILITY TO KEEP THIS INFORMATION UP TO DATE.)**

**5. IF WE CANNOT CONTACT THE PARENT OR THE CHILD'S PHYSICIAN, WE WILL DO ANY OR ALL OF THE FOLLOWING:**

**A. CALL ANOTHER PHYSICIAN**

**B. CALL A AMBULANCE**

**C. HAVE THE CHILD TAKEN TO AN EMERGENCY HOSPITAL IN THE COMPANY OF A STAFF MEMBER; STAFF VEHICLE; OR PROGRAM VEHICLE.**

**ANY EXPENSES INCURRED UNDER NO. 5 ABOVE, WILL BE BORNE BY THE CHILD'S FAMILY.**

**THE SCHOOL WILLNOT BE RESPONSIBLE FOR ANYTHING THAT MAY HAPPEN AS A RESULT OF FALSE INFORMATION GIVEN AT TIME OF ENROLLMENT.**

**SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_**



# 2024 - 2025

## MEDIA ACCESS POLICY PERMISSION FORM

THE MARK OF EXCELLENCE AFTERSCHOOL PROGRAM REQUIRE WRITTEN CONSENT OF PARENT(S) OR GUARDIAN(S) BEFORE STUDENTS CAN BE INTERVIEWED, FILMED OR PHOTOGRAPHED BY MEDIA REPRESENTATIVES. THIS INFORMATION MAY BE SHARED THROUGH VARIOUS COMMUNICATION OUTLETS, INCLUDING BUT NOT LIMITED TO SOCIAL MEDIA AND BROCHURES. WE MAY GET MEDIA COVERAGE OF MARK OF EXCELLENCE AFTERSCHOOL PROGRAM AFTER SCHOOL PROGRAM DURING THE SCHOOL YEAR. PLEASE READ AND SIGN THE RELEASE FORM BELOW.

I GIVE PERMISSION FOR MY CHILD TO BE INTERVIEWED, PHOTOGRAPHED, AND/OR FILMED BY MEDIA REPRESENTATIVES DURING MARK OF EXCELLENCE AFTERSCHOOL PROGRAM ACTIVITIES.

YES, I GIVE PERMISSION

NO, I DO NOT GIVE PERMISSION

I GIVE PERMISSION FOR MY CHILD TO HAVE PHOTO(S) AND /OR WORK SAMPLES PUBLISHED THROUGH THE MEDIA USING FIRST NAME ONLY.

YES, I GIVE PERMISSION

NO, I DO NOT GIVE PERMISSION

NAME OF STUDENT(S) \_\_\_\_\_ GRADE \_\_\_\_\_

PARENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_