



11 West 25<sup>th</sup> Street  
New York, NY 10010  
(212) 206-1461  
www.heartsogold.org

# Learning Center



## 2019 Registration Form

### PARTICIPANT (CHILD'S) INFORMATION:

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Gender  M  F Grade in September \_\_\_\_\_ School \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone number \_\_\_\_\_ E-mail \_\_\_\_\_

My child has an IEP:  Yes  No

My child will:  Walk or take public transportation home  be picked up

T-Shirt Size **Child**  Small  Medium  Large  X-Large **Adult**  Small  Medium  Large  X-Large

### S.T.E.A.M. Program:

Due to limited space in each subject area. Please choose your top 3 subject choices in order of preference:  
 \_\_\_\_ Science \_\_\_\_ Technology \_\_\_\_ Engineering \_\_\_\_ Art \_\_\_\_ Math

### MOTHER/GUARDIAN INFORMATION:

Name of Mother/Guardian registering child: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone number \_\_\_\_\_ E-mail \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION:

*Please list two contacts not already listed on this form will be used if the parent/guardian cannot be reached. Emergency Contacts listed below must be able to pick up participant in the event of an emergency.*

1. Name: \_\_\_\_\_ Relationship to Participant: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship to Participant: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### PHYSICIAN INFORMATION:

Child's Doctor's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Return Completed Application To: [qwheeler@shfinc.org](mailto:qwheeler@shfinc.org)  
 Program will take place at 210 W. 102<sup>nd</sup> Street (Between Amsterdam and Broadway)

# Learning Center



## 2019 Registration Form

**Allergies:**  Yes  No If yes, please list and describe: \_\_\_\_\_

### AUTHORIZATION/CONSENT:

Emergency Authorization: I understand that in the event of an emergency affecting my child while participating in the Hearts of Gold Learning Center's Summer of STEAM Program, a designated employee of Hearts of Gold Learning Center will attempt to contact me and inform me as soon as possible. In the event I cannot be reached, I hereby give permission for my child to be treated by a medical professional or hospitalized by a hospital selected by Hearts of Gold Learning Center.

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

### AUTHORIZED FOR PICK-UP

1. \_\_\_\_\_ (Name) (Contact #) (Relationship)

2. \_\_\_\_\_ (Name) (Contact #) (Relationship)

All participants may ONLY be picked up by the person (s) authorized by the registering parent/guardian in case of an emergency. The above named individuals must be 16 years old or older and allowed to pick up your child from Hearts of Gold Learning Center's Summer of STEAM Program.

### PERMISSION FORM

I hereby grant permission for my child to use all equipment and participate in all activities of the Hearts of Gold Learning Center's Summer of STEAM Program.

I hereby grant permission for my child to leave Hearts of Gold Learning Center's premises under proper supervision of Hearts of Gold Learning Center staff for walks, park, play and field trips. It is my understanding that these trips will be taken over the camp session without further consent from me.

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Parent/Guardian Name (Print)

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**My child may go home without an escort at the end of the day.**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

Return Completed Application To: [qwheeler@shfinc.org](mailto:qwheeler@shfinc.org).  
Program will take place at 210 W. 102<sup>nd</sup> Street (Between Amsterdam and Broadway)