

CIRCLE OF DISCIPLINE, INC.®

ENROLLMENT FORM

(Please complete one form for each participant)



Today's Date: _____

First Name: _____ Last Name: _____

Date of Birth: __/__/__

Gender: Male Female

Address _____

City _____ State _____ Zip Code _____

Occupation _____ Highest Grade Completed or Degree Earned _____

Home Phone (____) ____-____ Work Phone (____) ____-____

Cell Phone (____) ____-____ Email: _____

(If under 18 please complete parent information below)

Parent / Guardian's Name _____

Home Phone (____) ____-____ Work Phone (____) ____-____

Cell Phone (____) ____-____ Email: _____

Occupation _____

Does the child live with this parent or guardian? Yes No

Emergency Contact (If parent or guardian cannot be reached):

Name: _____ Relationship to You/Child: _____

Home Phone (____) ____-____ Work Phone (____) ____-____

Cell Phone (____) ____-____

Race / Ethnicity

- African American / Black, non Latino
- American Indian or / Alaskan Native
- Asian, Native Hawaiian or Pacific Islander
- Hispanic/Latino
- White, Non-Latino
- Other

School

- Public
- Charter School
- Faith-based
- Private
- Home School
- Other (please specify)

Grade Level ____ Name of school _____

FAMILY

How many people live in your household?

How many children, under 18, live in your household?

MEDICAL INFORMATION

Do you or your child(ren) have any of the following? <i>(Please check all that apply)</i>	If in school, do you or your child(ren) receive Special Education Services? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, please check all that apply)</i>
<input type="checkbox"/> Asthma	<input type="checkbox"/> Learning Disability
<input type="checkbox"/> Diabetes	<input type="checkbox"/> EBD (Emotional Behavioral Disorder)
<input type="checkbox"/> Weight	<input type="checkbox"/> ADD
<input type="checkbox"/> Other:	<input type="checkbox"/> ADHD
<input type="checkbox"/> None	<input type="checkbox"/> Autism
	<input type="checkbox"/> Other:

REFERRAL REASON TO COD PROGRAMMING

<input type="checkbox"/> Family Problems	<input type="checkbox"/> Personal Problems
<input type="checkbox"/> Educational problems	<input type="checkbox"/> Delinquent Offense
<input type="checkbox"/> Status Offense	<input type="checkbox"/> Health
<input type="checkbox"/> Other:	

REFERRAL INFORMATION

How did you hear about this program?

- Friend
- Family Member, Parent/Guardian
- Teacher (Teacher’s name and school): _____)
- School Principal / Counselor (Name and school): _____)
- Social Worker (Name and agency): _____)
- Court Ordered (Name of Judge): _____)
- Probation Officer (Name and County): _____)
- Other: _____
- Website: _____

Have you and/or your child(ren) attended a Circle of Discipline program before?

- Yes
- No

If yes, what program and when?

AUTHORIZATIONS FORM

Yes No

Screening Permission:

I authorize Circle of Discipline, Inc. and its designees to collect and record data on myself and/or child(ren). This data gathering may include, but is not restricted to the following:

- Surveys and interviews in regards to knowledge, attitudes, skills, and behaviors in academic and nonacademic development as well as overall satisfaction with *Circle of Discipline* programming.
- Academic assessments and school data such as grades and attendance.

Information will be collected by designated Circle of Discipline employees and analyzed by an outside contractor Circle of Discipline chooses. Overall end results will be utilized for reporting purposes to contracted agencies, identifying areas of success and/or improvements and securing program funding. Information collected will remain private, and only designated Circle of Discipline employees and contracted evaluator will have access to individual responses.

Yes No

Media / PR Photograph Permission/Research Authorization:

I give my permission for any pictures and/or video of myself and/or child(ren) to be used in Circle of Discipline displays, website, Facebook and other public relations documents. If any research, media or newspaper public relations are conducted at Circle of Discipline you will be notified in advance for written permission.

Yes No

Emergency Authorization:

In case of medical/dental emergency I hereby authorize Circle of Discipline staff to take myself and/or child(ren) to a health facility for treatment. I also authorize any licensed medical practitioner to provide whatever treatment is deemed necessary. I accept responsibility for any costs resulting from such treatment, which are not covered by my insurance and/or medical assistance. I understand that every attempt will be made to contact the parent/emergency contact.

Yes No

I hereby certify that the statements in this application are correct and true. I understand that my and/or child(ren)'s enrollment as a participant is based, in part, on the information provided within this application and my agreeing to the terms as outlined in writing by the Circle of Discipline, Inc. I have been told of the monthly membership fee, annual USA Boxing registration fee, volunteer responsibilities and various times of program activities.

Participant Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(If participant is under the age of 18)

Approved by: _____ Date: _____