

Program Application

“EXPLORE YOUR FUTURE AT McCANN”

Nov. 29 & 30 & Dec. 1

Dec. 6, 7, & 8

Dec. 12, 13, 15

Snow days Dec. 2, 9 & 16

3:00 p.m. - 4:30 p.m.

1. Please print all information.
2. You and your parent/guardian must sign the application
3. Please return by November 18, 2011. The first 130 in-district students will be accepted. Non-residents will be accepted on a space available first-come, first-served basis.
4. A copy of the McCann Emergency Form (attached) **MUST** be included with this application form.

STUDENT INFORMATION

Name: _____
(Initial) (Last) (First)

Town of Residence: _____

Address: _____
(House/Apt. Number) (Street)

Mailing Address _____

School Now Attending: _____

Current Grade: _____

Date of Birth: _____ Male _____ Female _____

Parent/Guardian Name: _____

(Parent/Guardian Signature)

(Student Signature)

September 30, 2011

DATES OF THE PROGRAM: November 29, 30, December 1, 6, 7, 8, 12, 13, 15
Snow days will be December 2, 9 & 16.

McCANN AFTERNOON CAREER AWARENESS PROGRAM BUS SCHEDULE:

Pick up from sending schools:

Drury High School	2:35 p.m.
Notre Dame	2:30 p.m.
St. Stanislaus Kostka School	2:45 p.m.
Clarksburg Elementary School	2:50 p.m.
Gabriel Abbott Elementary School	2:20 p.m.
Mt. Greylock Middle School	2:30 p.m.

PLEASE BE ON TIME!

Drop off points (made by buses leaving McCann at 4:30 p.m.)

North Adams - Davenport St. (Church St.)
Middle School
Notch Road
Greylock School (Phelps Avenue)

Adams - Howland Avenue (St. Thomas)
St. Stans
Old Stone Mill
Reynolds Store

Florida - Elementary School

Clarksburg - Elementary School (this bus continues on to
Williamstown)

Williamstown - Henderson Road
North Hoosac Road
Bridges Road
Williams Inn
Mt. Greylock Regional High School

Student Name

TOOL USE

McCann Tech will provide excellent instruction in all shop areas. However, it is necessary that you consent to your child's use of tools, machine and materials in order that he/she may work in each program during the "Career Awareness Program". If you wish your child to participate in the program, please sign the following statement:

**I HEREBY CONSENT TO THE USE OF THOSE TOOLS,
MACHINES AND MATERIALS WHICH ARE NECESSARY
FOR PARTICIPATION IN THE AFTERNOON "CAREER
AWARENESS PROGRAM."**

Date

Parent Guardian Signature

A COPY OF THE MCCANN EMERGENCY FORM **MUST** BE SENT WITH THE APPLICATION FORM.

Charles H. McCann Technical School
NORTHERN BERKSHIRE VOCATIONAL REGIONAL SCHOOL DISTRICT
70 HODGES CROSS ROAD – NORTH ADAMS, MA 01247

Student Name _____

Mailing Address _____
Last First (Full) Middle
City/Town Zip

Town of Residence _____ Phone _____

Date of Birth _____ City of Birth _____

Race _____ First Language _____ English Language Proficiency YES/NO
(Please Circle One)

Grade _____ Shop _____ Bus Number _____

Father's Name _____
Last First Initial

Address & Phone
(if Different From Above) _____

Place of Employment, Work Phone,
Cell Phone Nbr _____

Mother's Name _____
Last First Initial

Address & Phone
(if Different From Above) _____

Place of Employment, Work Phone,
Cell Phone Nbr _____

Student Resides With _____ Relationship To Student _____

IT IS UNDERSTOOD THAT BOTH PARENTS LISTED ON THIS DOCUMENT HAVE THE RIGHT TO DISMISS THE STUDENT.
IF A SPECIAL CIRCUMSTANCE EXISTS LEGAL DOCUMENTATION MUST BE PROVIDED.

Parent/Guardian

E-Mail Address (Either Home or Work) _____
[to be used to forward student progress reports and communicate with teachers]

IN CASE OF EMERGENCY OR ILLNESS: If parent/Guardian is not available, include name, address & phone
of emergency contact(s): _____

The permission signature portion will be kept in file for all four years of attendance.

AUTHORIZATION: I authorize the school's representative to transport, request and authorize treatment for my child in the event of an
Emergency: I agree that I will not hold this person liable while acting according to these directions.

Parent/Guardian Signature _____ **Date** _____

* * * * * **PARENT FIELD TRIP PERMISSION** * * * * *

I hereby give my child permission to accompany instructor(s) on educational field trips ~ either locally or out of town – by
bus or private cars and I indemnify and hold harmless the District and those for whom it is legally responsible against
any and all claims for personal injury to anyone other than my child and property damage caused in whole or in part by
child during my child's participation on a field trip. All school policies and rules apply while on a field trip.

Parent/Guardian Signature _____ **Date** _____

McCann Vocational Technical High School
CONFIDENTIAL EMERGENCY HEALTH INFORMATION
From the Desk of the School Nurse

PLEASE COMPLETE FORM & RETURN IMMEDIATELY!

Name: _____ Birth date: _____ Sex: M/F
 (Last) (First) (MI) (circle)

School: _____ Grade: _____ Teacher: _____ School Year: _____

ALERT TO PARENTS: If your child has a serious medical condition, it is vital that you discuss this with your School Nurse and teacher(s) immediately. It is very important to know of **LIFE THREATENING** conditions.

In order to provide a safe and healthy environment for your child this information will be accessible to the following people: School Nurse, your child's teacher, office manager, personnel responsible for health room coverage and emergency medical personnel.

A. **Medical History:** Check the ones that apply to your child and describe under the comment section.

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Headaches | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Anxiety/Panic attack | <input type="checkbox"/> Hearing Problem | (explain) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> PE activity |
| <input type="checkbox"/> Bee sting allergy | <input type="checkbox"/> Kidney/urinary | Limited _____ |
| <input type="checkbox"/> Bowel problem | problems | Not Limited _____ |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Muscle Disorder | Explain: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological Concern | _____ |
| <input type="checkbox"/> Color Blindness | <input type="checkbox"/> Orthopedic problem | _____ |
| <input type="checkbox"/> Epi-Pen | <input type="checkbox"/> Seizures | _____ |
| <input type="checkbox"/> Emotional Concerns | <input type="checkbox"/> Vision problems | _____ |

Comments: _____

B. **ALLERGIES:** List allergies your child has that cause a problem at school.

Cause of allergy: _____ Treatment: _____

Cause of allergy: _____ Treatment: _____

C. **MEDICATION:** (Include prescription, over-the-counter and herbal medication.)

Name	Used to treat	Taken at school?	
1) _____	_____	Yes___	No___
2) _____	_____	Yes___	No___
3) _____	_____	Yes___	No___

Before medication of any kind can be administered at school, a medication administration form, available in the office, must be completed by parent and physician and kept on file.

D. Does your student wear contact lens? _____ Glasses? _____ Hearing Aid? _____

E. Name of Physician: _____ Phone: _____

Name of Dentist: _____ Phone: _____

F. Health Insurance: _____ (OVER)

McCann Vocational Technical High School

**MEDICATION ADMINISTRATION IN SCHOOL
PART A: Written Parent/Guardian consent
For acetaminophen or ibuprofen**

Student: _____
(Last) (First)

Parent/Guardian: _____
(Please print)

Address: _____

Tel. # (Home): _____ Tel #. (Work) _____

Cellular #: _____ Pager #: _____

Email: _____

Other person(s), if any, to be notified in case of emergency if parent/guardian is unavailable:
Name: _____ Tel #: _____

Relationship: _____

CONSENT

1. I give permission for the School Nurse to utilize the following as needed per standing school physician order: (Please check appropriate items):

- | | | |
|--|--|---|
| <input type="checkbox"/> Throat lozenges | <input type="checkbox"/> Benadryl for rash or hives | <input type="checkbox"/> Hydrocortisone cream |
| <input type="checkbox"/> Cough drops | <input type="checkbox"/> Epipen for life-threatening allergy | <input type="checkbox"/> Anbesol/Orajel |
| <input type="checkbox"/> Antacid tablets | <input type="checkbox"/> Triple antibiotic ointment | |

2. I give permission to the School Nurse (or school personnel designated by the School Nurse) to give my child (as listed above) the following medicine:
 Acetaminophen 650 mg po, (generic Tylenol), or
 Ibuprofen 400 mg po (generic Motrin),
No more than once per day for headache, (excluding head injury), menstrual cramps or pain per nursing assessment.

Signature _____ DATE: _____

Relationship to student: _____