

## 32N OUT-OF-SCHOOL TIME PROGRAM ENROLLMENT FORM

Program \* \_\_\_\_\_  Before School  After School  Summer

### STUDENT INFORMATION

Student Name \* \_\_\_\_\_

Address \_\_\_\_\_

Zip Code \* \_\_\_\_\_

Phone Number \_\_\_\_\_ Date of Birth \* (mm/dd/yyyy) \_\_\_\_\_

School Name \_\_\_\_\_ Grade Level \* \_\_\_\_\_

Gender \*  Female  Male  Nonbinary/Some other gender  Prefer not to disclose

#### Race/Ethnicity \* (check all that apply)

- American Indian/Alaskan Native
- Asian
- Black/African American
- Hispanic/Latino
- Middle Eastern/North African
- Native Hawaiian/Pacific Islander
- White
- Prefer not to disclose

#### Transportation Home (check all that apply)

- Pick Up/Drive  Walk  Bus  Other: \_\_\_\_\_

Are siblings enrolled?  No  Yes

Siblings' Names: \_\_\_\_\_

### SCHOOL CONTACT INFORMATION (For Teacher survey; not required for summer-only youth or programs)

Contact Name \* \_\_\_\_\_

Contact Email \* \_\_\_\_\_

Contact Type \*  Teacher  Counselor

### PARENT/LEGAL GUARDIAN CONTACT INFORMATION

PARENT/GUARDIAN 1  Authorized to Pick Up

Name \* \_\_\_\_\_

Relationship to Student\* \_\_\_\_\_

Phone Number\* \_\_\_\_\_

Email \* \_\_\_\_\_

Address \_\_\_\_\_

Zip Code \_\_\_\_\_

PARENT/GUARDIAN 2  Authorized to Pick Up

Name \* \_\_\_\_\_

Relationship to Student\* \_\_\_\_\_

Phone Number\* \_\_\_\_\_

Email \* \_\_\_\_\_

Address \_\_\_\_\_

Zip Code \_\_\_\_\_

### EMERGENCY CONTACTS (AUTHORIZED FOR PICK UP IF NEEDED)

#### EMERGENCY CONTACT #1

Name \_\_\_\_\_

Relationship to Student \_\_\_\_\_

Phone Number 1 \_\_\_\_\_

Phone Number 2 \_\_\_\_\_

#### EMERGENCY CONTACT #2

Name \_\_\_\_\_

Relationship to Student \_\_\_\_\_

Phone Number 1 \_\_\_\_\_

Phone Number 2 \_\_\_\_\_

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## HEALTH AND MEDICAL INFORMATION

**Please Mark Below if Student Has Needs Related to (check all that apply):**

- Allergies   
  Asthma   
  Diabetes   
  Hearing Impairment   
  Heart Troubles   
  Learning Disability  
 Physical Limitation   
  Seizures   
  Vision Problems   
  Other: \_\_\_\_\_

**Food Allergies:** \_\_\_\_\_ **Allergic to Bees?**   
 Yes   
 No   
 I don't know

**Any other health concerns we should know about?** \_\_\_\_\_

**Name and Phone Number of Student's Physician/Health Clinic** \_\_\_\_\_

**Preferred Hospital for Medical Treatment** \_\_\_\_\_

## PARENT/LEGAL GUARDIAN CONSENT AND AUTHORIZATIONS

This program receives funding from the State of Michigan to serve your child. Michigan State University and Public Policy Associates are contracted to evaluate program quality and impacts. **By enrolling my child in this program, I agree that the program will share the asterisked \* attendance and demographic information with the contracted evaluators. All data will be kept confidential.**

**Read each statement and write your initials to indicate agreement:**

- \_\_\_\_\_ Enrollment in the program is voluntary. I understand that regular attendance is expected.
- \_\_\_\_\_ I have received a copy of the family handbook. I agree to the program's policies. I will tell the program if my contact information changes.
- \_\_\_\_\_ I understand that the program's playground equipment may not fully comply with licensing standards.
- \_\_\_\_\_ I give my permission for my child to attend field trips. Program staff will give me information about field trips in advance. I agree that the program is not responsible if my child has a medical emergency during a field trip.
- \_\_\_\_\_ I have told staff about any restrictions to my child's activities.
- \_\_\_\_\_ My child's immunization records are up to date. I agree to provide the immunization record or appropriate waiver with the program upon request.
- \_\_\_\_\_ If my child needs medication during the program, I will give the site manager (a) a medication authorization form and (b) the medication in its original prescription bottle.
- \_\_\_\_\_ I give the staff permission to get emergency medical treatment for my child. Emergency treatment may include surgery.
- \_\_\_\_\_ I give the staff permission to apply insect repellent, sunscreen, and antibacterial cleanser to my child's skin when needed. I can ask for specific information about these products.

**Student Name** \_\_\_\_\_ **Parent/Guardian Name** \_\_\_\_\_

**Date** (mm/dd/yyyy) \_\_\_\_\_ **Parent/Guardian Signature** \_\_\_\_\_

## INTERNAL USE ONLY Asterisked\* Data Entered in EZReports

**Admission Date \*** \_\_\_\_\_ **Discharge Date \*** \_\_\_\_\_