32N OUT-OF-SCHOOL TIME PROGRAM ENROLLMENT FORM

Program * Pathfinders of Muskegon ☐ 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

***If your child has multiple allergies, provide a list of allergies, medications, and procedures.**

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

☐ Lactose Intolerant (Dairy Allergy)

☐ Allergies ☐ Asthma ☐ Diabetes ☐ Hearing Impairment ☐ Heart Troubles ☐ Learning Disability

☐ Physical Limitation ☐ Seizures ☐ Vision Problems ☐ Other: Select item or write inside box

Other Food Restrictions or Allergies _____

Allergic to Bees? ☐ Yes ☐ No ☐ I don't know

Any other health concerns or MEDICATIONS 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 *** _____

Submit