MiLEAP
Michigan Department of Lifelong Education, Advancement, and Potential

MASP
Michigan Afterschool Partnership

32N OUT-OF-SCHOOL TIME PROGRAM ENROLLMEN

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 PICKUP 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):

☐ 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 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 F Associates are contracted to evaluate program quality and impacts. **By enrolling my child in this program, I agre the program will share the asterisked * attendance and demographic information with the contracted eval 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 r 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 t advance. I agree that the program is not responsible if my child has a medical emergency during a field t

________ 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 appropriat with the program upon request.

________ If my child needs medication during the program, I will give the site manager (a) a medication authorizati 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 surgery.

________ I give the staff permission to apply insect repellent, sunscreen, and antibacterial cleanser to my child's sk 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