

**Marquette Area Public Schools**  
**Child & Family Services-Before/After School & Kinder Club Programs**  
**INDIVIDUAL STUDENT RECORD (2009-2010)**

Date of Enrollment: \_\_\_\_\_ Date of Withdrawal \_\_\_\_\_ En Fee Paid \_\_\_\_\_ DB \_\_\_\_\_ APF \_\_\_\_\_

**COMPLETE EVERY LINE ON THIS FORM TO ENSURE THE WELL-BEING OF YOUR CHILD**

(Some of the information is required for statistical purposes only)

Name of Child \_\_\_\_\_ D.O.B. \_\_\_\_\_  
 (Last) (First) (Middle)  
 School \_\_\_\_\_ Grade \_\_\_\_\_ Gender \_\_\_\_\_ Living with \_\_\_\_\_  
 Race/Ethnicity \_\_\_\_\_ Name(s) of siblings enrolled? \_\_\_\_\_

Mother/Guardian's Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_  
 Home address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
 Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Hours of work \_\_\_\_\_ E-mail address \_\_\_\_\_  
 Authorized to pick up  Not Authorized (Please provide legal proof)  Deceased  Lives out of Area

Father/Guardian's Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_  
 Home address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
 Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Hours of work \_\_\_\_\_ E-mail address \_\_\_\_\_  
 Authorized to pick up  Not Authorized (Please provide legal proof)  Deceased  Lives out of Area

Please indicate if your child qualifies for:  Free/Reduced Hot Lunch  DHS assistance

**My child will attend on the following days:**

**BEFORE SCHOOL PROGRAM**

Mon. Tues. Weds. Thurs. Fri.

Schedule Varies

**AFTER SCHOOL PROGRAM**

Mon. Tues. Weds. Thurs. Fri.

Schedule Varies

**KINDER CLUB PROGRAM**

Mon. Tues. Weds. Thurs. Fri.

Schedule Varies

**IN CASE OF ACCIDENT OR ILLNESS, I REQUEST BEFORE/AFTER SCHOOL PROGRAM STAFF CONTACT ME, OR THE PERSON LISTED BELOW IF I AM UNAVAILABLE. I HEREBY AUTHORIZE CHILD & FAMILY SERVICES STAFF TO SECURE MEDICAL TREATMENT FOR AN ACUTE EMERGENCY BY CALLING 911.**

Alternate Contact Person \_\_\_\_\_ Phone \_\_\_\_\_  
 Doctor \_\_\_\_\_ Phone \_\_\_\_\_  
 Preferred Hospital \_\_\_\_\_ Phone \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Insurance No. \_\_\_\_\_

PERSONS (other than parents) AUTHORIZED TO PICK UP YOUR CHILD: (Please list at least 1 OTHER name)

1. Name \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_  
 2. Name \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_  
 3. Name \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

**NOTE:** If a parent/guardian/authorized person arrives late to pick up their child (after 5:30 p.m.), a **LATE FEE** of \$5.00 will be charged for each 15 minute increment they are late. If a parent/guardian/authorized person has not arrived by 6:00 p.m., the police will be called and the child will be released to them. The police will then take responsibility to locate the parent.

\*\*\*\*\***MORE INFORMATION REQUIRED ON BACK OF FORM**\*\*\*\*\*

| <b>HEALTH HISTORY for _____</b>                                   |     |    |
|---|-----|----|
| Is your child having any of the problems listed below?            | YES | NO |
| 1. Allergies or reactions (i.e., food, medication, or other)      |     |    |
| 2. Hay fever, asthma, or wheezing                                 |     |    |
| 3. Eczema or frequent skin rashes                                 |     |    |
| 4. Convulsion/Seizures  |     |    |
| 5. Heart trouble  |     |    |
| 6. Diabetes   |     |    |
| 7. Frequent colds, sore throats, earaches (four or more per year) |     |    |
| 8. Trouble with passing urine or bowel movements                  |     |    |
| 9. Shortness of breath  |     |    |
| 10. Speech problems   |     |    |
| 11. Taking any medications regularly                              |     |    |
| 12. Other (Please define below)                                   |     |    |
| <b>Please explain any problem areas identified above:</b>         |     |    |
|   |     |    |
|   |     |    |
|   |     |    |

**IMMUNIZATIONS & GENERAL HEALTH ASSESSMENT**

My child has had all required immunizations and is free from communicable disease, is in good health and is able to fully participate in the Before/After School Program activities.  Yes  No  
 His/her immunization record and/or school physical is on file in the school office.  Yes  No  
 Date of last Tetanus Shot \_\_\_\_\_  
 (This is normally included in the DTP series of shots a child receives prior to kindergarten)

May Child and Family Services photograph your child?  Yes  No  
 If yes, may we use the photo for advertising/publicity?  Yes  No  
 May CFS provide and apply SPF 30 Sunscreen for your child?  Yes  No

**PERMISSION**

I hereby give my permission to Marquette Area Public Schools/Child and Family Services of the U.P., Inc. for my child to participate in field trips and when necessary be transported in an approved vehicle.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**AGREEMENT**

I have read ALL THE INFORMATION in the Child and Family Services Before/After School Program enrollment packet and agree to abide by all the policies and regulations. I also understand that the School Programs are a collaboration between Child & Family Services of the U.P., Inc. and Marquette Area Public Schools. Information regarding attendance, behavior and programming will be shared between program staff and appropriate school personnel when deemed necessary. I also agree to abide by the above stated rates.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_