MiLEAP Michigan Department of Lifelong Education, Advancement, and Potential | Out-of-School Time Learning

Out-of-School Time Enrollment Form 2026-2027

Program Site: _____ **School Name:** _____

Student Name: _____ **D.O.B.:**_____ **Gender**: ☐ Male ☐ Female ☐ Nonbinary

Address:_____ **Primary Phone:** (____)_____
Number & Street, Apartment Number City State Zip

Student's Primary Language: ☐ English ☐ Spanish ☐ Other:_____

T-Shirt Size: ____ ☐ Youth ☐ Adult

Student Grade:_____ **Teacher's Name:**_____ **Teacher's Email:**_____
(as enrolled for 2026-27 school year)

Before School Program	Afterschool Program
☐ Yes ☐ No	☐ Walk ☐ Bus (if applicable) ☐ Pick Up

Are siblings enrolled? ☐ Yes ☐ No If so, at which school/program? _____

Names of Siblings: _____

Student Race/Ethnicity (check all that apply):
- ☐ American Indian/ Native Alaskan
- ☐ Asian
- ☐ Black/African American
- ☐ Hispanic/Latino
- ☐ Middle Eastern/North African
- ☐ Native Hawaiian/ Pacific Islander
- ☐ White
- ☐ Other: _____
- ☐ Prefer not to say

Parent 1/Legal Guardian

Name: _____

Email: _____

Same as Address as Child? ____Yes ____No (If no, please provide)

Address: _____
Name & Street, Apartment Number

_____
City State Zip

Phone Number: _____
Cell Work

Authorized to Pick-up? ____Yes ____ No

Parent 2/Legal Guardian

Name: _____

Email: _____

Same as Address as Child? ____Yes ____No (If no, please provide)

Address: _____
Name & Street, Apartment Number

_____
City State Zip

Phone Number: _____
Cell Work

Authorized to Pick-up? ____Yes ____ No

INTERNAL USE ONLY: **Date of Admission**: _____ **Date of Discharge**: _____

This before-school, after-school, and/or summer program is made possible by a grant awarded by MiLEAP under OST Grants Program.

In the event of a medical emergency, what is the hospital preferred for medical treatment: _____

Medical Conditions/Allergies/Disabilities or Special Instructions ("check" conditions that apply or check "none"): ____ NONE

____ Allergies ____ Asthma ____ Diabetes ____ Hearing Impairment ____Heart ____ Physical Limitation ____ Seizures ____ Vision ____ Requires Epi-Pen

Food allergies? _____ Allergic to Bees? ____YES ____NO Other:_____

If medication is to be distributed during the program, I understand that a medication authorization form must be on file with the program leadership

_____ (initials) and it is my responsibility to make sure the leadership has the authorized medication to be administered in a timely manner _____ (initials)

Please describe any Special Instructions/Information that may be useful for staff to know: _____

_____

******Additional Contacts can be used for transporting of my student if I am not available _____ (initials)******

EMERGENCY CONTACT 1	EMERGENCY CONTACT 2	EMERGENCY CONTACT 3
Name: _____	Name: _____	Name: _____
Phone: _____	Phone: _____	Phone: _____
Add'l Phone: _____	Add'l Phone: _____	Add'l Phone: _____
Relationship to Student: _____	Relationship to Student: _____	Relationship to Student: _____

YES	NO	****PLEASE READ THE STATEMENTS BELOW AND CHECK THE BOX NEXT TO EACH STATEMENT****
		Emergency Medical Treatment: I give permission to the program staff (licensed by the State of Michigan) to secure emergency medical and/or surgical treatment for the above.
		Family Handbook: I have received a copy of the Family Handbook. I agree to the program's policies.
		Playground Equipment Recognition. The program utilizes the playground equipment available at our sites. I understand the equipment students use may not comply with licensing standards.
		Immunization Records. My Child's immunization records are up-to-date. The immunization record or appropriate waiver is on file with the school. My child is in good health with activity restrictions noted.
		Contact Information. I agree to contact the program leadership at my site if my contact information changes.
		Field Trip. I hereby give my permission for my student to attend field trips. I understand that information will be provided prior to every field trip. I agree to accept all medical responsibility in case of emergency due to accident or illness.
		Topical Application Waiver. I give permission to the program staff to provide my child with insect repellant, sunscreen, and Neosporin wound cleanser when appropriate. I understand that specific product information is available upon my request from the program leadership team.
		Program Enrollment. I understand that enrollment in this program is voluntary. In order to assure that each student makes the desired progress for academic success, I understand regular attendance is expected.
By signing my student up, I authorize this program to collect and use data about my child for the purposes of program development, safety, and improving educational outcomes. I understand that this data will be kept confidential, stored securely, and used by authorized personnel within the organization, and shared with Michigan Department of Lifelong Education, Advancement, and Potential (MiLEAP) OST Grants Program and state evaluation partners.		

This before-school, after-school, and/or summer program is made possible by a grant awarded by MiLEAP under OST Grants Program.