_________ Date Child's Enrollment Began
_________ Date Child's Enrollment Ended

ENROLLMENT FORM - GREAT AFTER-SCHOOL PLACE

Child's Name	Preferred Name/Nickname	Birth Date	Grade	Sex	Circle the days of G.A.P. attendance	School of attendance
______________________	______________________	__________	_____	____	M T W H F	______________
______________________	______________________	__________	_____	____	M T W H F	______________

Allergies & other Medical Conditions (i.e. asthma, diabetes, epilepsy, physical limitations, etc.): ________________________________

____

Parent/Guardian Name____ email______________________________________

Home Address____ Cell Phone ____________________

Place of Work ____ Work Phone ____________________

Work Schedule____

Parent/Guardian Name____ email______________________________________

Home Address (if different than above)____ Cell Phone ____________________

Place of Work ____ Work Phone ____________________

Work Schedule____

Parent's Marital Status: ____Married ____Separated ____Divorced ____Remarried ____Parent Deceased ____Single

Custody Arrangements? ____

Is anyone restricted from seeing the child (ren)? Is so, please list. ____

Other members in the household (including adults & children)

Name	Relationship to child
____	____
____	____
____	____

EMERGENCY NUMBERS: In an emergency, parents will be contacted immediately. Please provide two other contacts that live or work in Brookings and their phone numbers that are valid during program hours.

Name	Relationship	Phone Number
____	______________________________	___________________
____	______________________________	___________________

Who, other than parents, is authorized to pick up your child (ren)? Any change in this list must be received from you in writing.

1. ____
   Name & Phone Number

2. ____
   Name & Phone Number

3. ____
   Name & Phone Number

4. ____
   Name & Phone Number

(Please complete the other side.)

Emergency Medical Care Authorization

If emergency medical care is deemed necessary and I cannot be contacted, I authorize the G.A.P. staff to act on my behalf in granting permission for my child to receive emergency treatment. Please note that my child is allergic to the following medications: ____ It is also important to note that my child has the following special medical conditions:____

Child/Family Physician:

______________________	______________________	______________
Physician Name	Clinic	Phone Number

______________________	______________________	______________
Parent/Guardian Signature	Parent/Guardian Signature	Date

PHOTOGRAPHIC PERMISSION: I DO I DO NOT (circle one) give permission to have my child appear in any media coverage approved by the Great After-School Place. I understand that the Site Supervisor, in conjunction with the Coordinator, has been given the authority by the G.A.P. Board of Directors to determine appropriate requests. If I have not circled either choice, I understand that G.A.P. will assume that I DO agree.

I DO I DO NOT (circle one) give permission to G.A.P. staff to consult with school personnel concerning my child's homework needs, behavior, IEP/504, and any health-related situations (including COVID 19 positive tests, close contact quarantining, allergies, hospitalizations, etc.). Parents will be informed of any shared information.

Is there any additional information you would like to share about your child? (Favorites, food likes, special interests or fears, etc)

____

Optional: Children's racial and ethnic information

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we Are fully serving our community. Responding to this section does not affect your child's enrollment with G.A.P.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ Black or African American ☐ White ☐ Other_______________

Civil Rights Statement:

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or

(2) fax: (833) 256-1665 or (202) 690-7442; or

(3) email: program.intake@usda.gov

This institution is an equal opportunity provider.

I/We attest that the information listed on this application is as accurate and complete as possible.

______________________	______________________	__________
Parent Signature	Parent Signature	Date

Parent Initials and Date ____________________ ____________________ ____________________