



Wayne County Action Program, Inc. || Lyons Advantage After-School Program

2020-2021

Advantage After-School Program Registration Application

Child's Name:	
Child's Teacher:	Grade:
Caregiver's Name:	
Caregiver's Cell Phone Number:	
Caregiver's Work Phone Number:	
Essential Employee: <input type="checkbox"/> YES <input type="checkbox"/> NO	

This Portion Completed by Staff:

RECEIVED BY ADVANTAGE STAFF	DATE:	INITIALS:
COMPLETED: <input type="checkbox"/> YES <input type="checkbox"/> NO		
WAITLISTED: <input type="checkbox"/> YES <input type="checkbox"/> NO, START DATE OF:		

COPA FAMILY ID:	COPA CHILD ID:	ENTERED DATE:	INITIALS:
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Child Application

Each child in a family must have their own form filled out completely.

Enrolling Child Information

Name: _____ Address: _____	Application Date: _____ Grade Level : _____ Teacher: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other _____ DOB: _____ SSN: _____
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Child Demographic Information

Primary Language: _____ <input type="checkbox"/> Preferred Language <input type="checkbox"/> Dual Language Learner	Secondary Language: _____ <input type="checkbox"/> Preferred Language	Ethnicity: <input type="checkbox"/> Hispanic or Latino Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Bi-racial/Multi-racial <input type="checkbox"/> Black or African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Unspecified <input type="checkbox"/> Other _____
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Child Health Information

Disability Status: <input type="checkbox"/> None <input type="checkbox"/> Suspected <input type="checkbox"/> Certified IEP <input type="checkbox"/> Certified IFSP IEP/IFSP Date: _____ Exp. Date: _____ Primary Diagnosis: _____	<input type="checkbox"/> Child has a Medical Card <input type="checkbox"/> Child is receiving a Childcare Subsidy <input type="checkbox"/> Child was referred by Child Welfare	<input type="checkbox"/> Allergies to Medications _____ <input type="checkbox"/> Food Allergy/Intolerance _____ <input type="checkbox"/> Chronic Condition _____ <input type="checkbox"/> Prescribed Medication _____
Health Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No Insurance Provider: _____ <input type="checkbox"/> Insurance Referral Needed	Primary Care Physician: _____ Physician Phone Number: _____ Date of Last Physical: _____	Primary Dentist: _____ Dentist Phone Number: _____ Date of Last Exam: _____ <input type="checkbox"/> Dental Concerns: _____ <input type="checkbox"/> Referral Needed <input type="checkbox"/> Dental Home Referral Needed

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Universal Family Application

Primary Adult (Caregiver) Demographic Information

Name: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other _____ DOB: _____	SSN: _____ <input type="checkbox"/> Random SSN Public Assistance: <input type="checkbox"/> TANF <input type="checkbox"/> WIC <input type="checkbox"/> FS/SNAP
Primary Language: _____ <input type="checkbox"/> Preferred Language	Secondary Language: _____ <input type="checkbox"/> Preferred Language	Ethnicity: <input type="checkbox"/> Hispanic or Latino Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Bi-racial/Multi-racial <input type="checkbox"/> Black or African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Unspecified <input type="checkbox"/> Other _____
Education Level: _____ Name: _____ Contact: _____	Employment Status: _____ Name: _____ Contact: _____	Military Status: <input type="checkbox"/> Active Duty <input type="checkbox"/> Veteran

Primary Adult Contact Information

Primary Phone: _____	Secondary Phone: _____	Email: _____
Address: _____ City: _____ State: _____ Zip: _____ County: _____ <input type="checkbox"/> Permanent <input type="checkbox"/> Mailing		
Address: _____ City: _____ State: _____ Zip: _____ County: _____ <input type="checkbox"/> Permanent <input type="checkbox"/> Mailing		

Household Structure

Family Structure: <input type="checkbox"/> Single Parent/Person <input type="checkbox"/> Two Parent/Person Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Other _____	Parent(s)/Guardian(s) Best Descriptor: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Parents <input type="checkbox"/> Grandparent(s) <input type="checkbox"/> Other Relative <input type="checkbox"/> Foster Parent(s) <input type="checkbox"/> Other _____	Family Type: <input type="checkbox"/> Single Parent/Female <input type="checkbox"/> Single Parent/Male <input type="checkbox"/> Two-Parent Household <input type="checkbox"/> Two-Parent Unmarried <input type="checkbox"/> Single Person <input type="checkbox"/> Two Adults (No Children) <input type="checkbox"/> Non-related Adults with Children <input type="checkbox"/> Multigenerational Household <input type="checkbox"/> Unknown/Not Reported <input type="checkbox"/> Other _____
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Primary Adult (Participant) Eligibility Information

Disabled: <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> No Mental Health Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No Medical Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____		Income: \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Child Support \$ _____ <input type="checkbox"/> Unemployment \$ _____ <input type="checkbox"/> TANF \$ _____ <input type="checkbox"/> SSI \$ _____ <input type="checkbox"/> SSDI \$ _____
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Housing Information

# in Family (*Supported by Primary Caregiver's Income): _____ # in Household (*# of people in the home): _____	Current Housing: <input type="checkbox"/> Homeless <input type="checkbox"/> Rent <input type="checkbox"/> Own <input type="checkbox"/> Other _____ <input type="checkbox"/> Other Permanent Housing <input type="checkbox"/> Unknown/Not Reported Current Housing Date: _____	Previous Housing: <input type="checkbox"/> Homeless <input type="checkbox"/> Rent <input type="checkbox"/> Own <input type="checkbox"/> Other _____ <input type="checkbox"/> Other Permanent Housing <input type="checkbox"/> Unknown/Not Reported
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COPA FAMILY ID:

10062020

COPA CHILD ID:

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Secondary Adult (Caregiver) Demographic Information

Name: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other _____ DOB: _____	SSN: _____ <input type="checkbox"/> Random SSN Public Assistance: <input type="checkbox"/> TANF <input type="checkbox"/> WIC <input type="checkbox"/> FS/SNAP
Primary Language: _____ <input type="checkbox"/> Preferred Language	Primary Language: _____ <input type="checkbox"/> Preferred Language	Ethnicity: <input type="checkbox"/> Hispanic or Latino Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Bi-racial/Multi-racial <input type="checkbox"/> Black or African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Unspecified <input type="checkbox"/> Other _____
Education Level: _____ Name: _____ Contact: _____	Employment Status: _____ Name: _____ Contact: _____	Military Status: <input type="checkbox"/> Active Duty <input type="checkbox"/> Veteran

Secondary Adult Contact Information

Primary Phone: _____	Secondary Phone: _____	Email: _____
Address: _____ City: _____ State: _____ Zip: _____ County: _____	<input type="checkbox"/> Permanent <input type="checkbox"/> Mailing	
Address: _____ City: _____ State: _____ Zip: _____ County: _____	<input type="checkbox"/> Permanent <input type="checkbox"/> Mailing	

Household Member Information

Name: _____	DOB: _____	Gender: _____	Employed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Education Level: _____	Relation to Primary: _____
Name: _____	DOB: _____	Gender: _____	Employed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Education Level: _____	Relation to Primary: _____
Name: _____	DOB: _____	Gender: _____	Employed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Education Level: _____	Relation to Primary: _____
Name: _____	DOB: _____	Gender: _____	Employed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Education Level: _____	Relation to Primary: _____

Additional Comments

Certification of Information

I certify the information provided in this entire registration packet and proof is accurate and truthful to the best of my knowledge. Providing false information could result in dismissal from the program.

I understand that this application may be subject to rejection if not filled out completely.

Primary Caregiver Name (Print)

Primary Caregiver Signature & Date

COPA FAMILY ID:	COPA CHILD ID:	ENTERED DATE:	INITIALS:
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Emergency Contact Information

If there are any custodial agreements, court orders, or court documents in place the most recent copy is required.
Please attach.

Name: _____ Phone: _____ <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> H Phone: _____ <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> H Phone: _____ <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> H	Relation to Child: _____ Language: _____ Address: _____	<input type="checkbox"/> Joint Custodial Parent <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Child can be released to this person <input type="checkbox"/> Emergency Closing Destination
Name: _____ Phone: _____ <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> H Phone: _____ <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> H Phone: _____ <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> H	Relation to Child: _____ Language: _____ Address: _____	<input type="checkbox"/> Joint Custodial Parent <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Child can be released to this person <input type="checkbox"/> Emergency Closing Destination
Name: _____ Phone: _____ <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> H Phone: _____ <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> H Phone: _____ <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> H	Relation to Child: _____ Language: _____ Address: _____	<input type="checkbox"/> Joint Custodial Parent <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Child can be released to this person <input type="checkbox"/> Emergency Closing Destination
Name: _____ Phone: _____ <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> H Phone: _____ <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> H Phone: _____ <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> H	Relation to Child: _____ Language: _____ Address: _____	<input type="checkbox"/> Joint Custodial Parent <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Child can be released to this person <input type="checkbox"/> Emergency Closing Destination
Name: _____ Phone: _____ <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> H Phone: _____ <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> H Phone: _____ <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> H	Relation to Child: _____ Language: _____ Address: _____	<input type="checkbox"/> Joint Custodial Parent <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Child can be released to this person <input type="checkbox"/> Emergency Closing Destination
Name: _____ Phone: _____ <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> H Phone: _____ <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> H Phone: _____ <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> H	Relation to Child: _____ Language: _____ Address: _____	<input type="checkbox"/> Joint Custodial Parent <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Child can be released to this person <input type="checkbox"/> Emergency Closing Destination
Restricted Pick-Up		
Name: _____	Reason: _____	<input type="checkbox"/> Court Order Effective Date: _____
Name: _____	Reason: _____	<input type="checkbox"/> Court Order Effective Date: _____
Name: _____	Reason: _____	<input type="checkbox"/> Court Order Effective Date: _____
Name: _____	Reason: _____	<input type="checkbox"/> Court Order Effective Date: _____

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Consent & Release of Information

Child(ren)'s Name(s):

If any information is different, please attach necessary information

As indicated below, I hereby give permission to the Advantage After-School Program to provide the following services to my child:

- ☐ 1. Collaborative after-school enrichment activities and workshops offered;
- i. 21CCLC enrichment activity leaders may sign my child out to participate in their workshop
- ☐ 2. Basic First Aid by Program Staff including application of topical antibiotic ointments in cases of cuts and scrapes;
- ☐ 3. Receive and/or release information (educational/therapeutic and/or medical) to/from:
- i. Home School District (REQUIRED)
- ii. Primary Care Physician. Physician's Name: _____
- iii. Health Facility Personnel (i.e. hospitals, doctors & specialists in the event of an emergency).
- iv. Collaboration with other programs within/or outside the Wayne County Action Program Inc., in which the family is enrolled (List programs family is enrolled in):
- _____
- _____
- _____
- v. Special Services Providers: _____
- vi. Other (Specified by Family Members): _____
- ☐ 4. Photographs and videotaping taken and used in:
- i. Classroom (i.e. albums, posters, etc.)
- ii. Print and digital media;
- ☐ 5. Water play under adult supervision in a sprinkler or water table;
- ☐ 6. My child can attend walking and school district transported field trips off school grounds;
- ☐ 7. Application of protective sunscreen – SPF 30 (provided);
- ☐ 8. Confidential and secure storage of the information contained in this registration packet on COPA, a centralized online database. By signing this form, I am showing I understand that: The purposed of securely storing information in COPA is to help improve the services I receive; My information will be used to ensure Wayne County Action Program, Inc., will provide the most comprehensive services to me and/or my family; The Wayne CAP Program serving me is required to utilize COPA for all customers; I am entitled to a copy of this COPA Acknowledgement; The list of Wayne CAP Programs that may have access to my information is in the PARENT HANDBOOK I received today, and can be found on the agency website www.waynecap.org.
- ☐ 9. I have been given a Parent Handbook for the school year. I have read and understand the contents and agree to fulfill what is expected of me as a Parent/Guardian. My child and I both understand that the school code of conduct applies to both Advantage.

Parent/Guardian Name (Print)

Staff Name (Print)

Parent/Guardian Signature Date

Staff Signature Date

COPA FAMILY ID:

COPA CHILD ID:

ENTERED DATE:

INITIALS:

10062020

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