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:	
Virtual Learner:	☐YES	☐NO	☐ OTHER: ____________________
Caregiver's Name:			
Caregiver's Cell Phone Number:			
Caregiver's Work Phone Number:			
Essential Employee:	☐YES	☐NO	

This Portion Completed by Staff:

Received by Advantage Staff	Date:	Initials:
Completed: ☐YES	☐NO	
Waitlisted: ☐YES	☐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: ____________	☐ Male ☐Female ☐Other _____ DOB: ____________ SSN: ______________________

Child Demographic Information

Primary Language:______________ ☐Preferred Language ☐Dual Language Learner	Secondary Language:___________ ☐Preferred Language	Ethnicity: ☐Hispanic or Latino Race: ☐ American Indian or Alaska Native ☐Asian ☐ Bi-racial/Multi-racial ☐ Black or African American ☐ Caucasian ☐ Native Hawaiian or other Pacific Islander ☐Unspecified ☐Other __________

Child Health Information

Disability Status: ☐None ☐Suspected ☐Certified IEP ☐Certified IFSP IEP/IFSP Date: _______ Exp. Date: ______ Primary Diagnosis: ____________________	☐Child has a Medical Card ☐Child is receiving a Childcare Subsidy ☐Child was referred by Child Welfare	☐Allergies to Medications ______________________________ ☐Food Allergy/Intolerance ______________________________ ☐Chronic Condition ______________________________ ☐Prescribed Medication ______________________________
Health Insurance: ☐Yes ☐No Insurance Provider: ___________________ ☐Insurance Referral Needed	Primary Care Physician: _______________ Physician Phone Number: ______________ Date of Last Physical: ___________	Primary Dentist: ________________ Dentist Phone Number: ______________ Date of Last Exam: ___________ ☐Dental Concerns: ___________________ ☐Referral Needed ☐Dental Home Referral Needed

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

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Universal Family Application

Primary Adult (Caregiver) Demographic Information

Name: ______________________________	☐ Male ☐Female ☐Other ________ DOB: ____________	SSN: _________________ ☐Random SSN Public Assistance: ☐TANF ☐WIC ☐FS/SNAP
Primary Language:_______________ ☐Preferred Language	Secondary Language:___________ ☐Preferred Language	Ethnicity: ☐Hispanic or Latino Race: ☐ American Indian or Alaska Native ☐Asian ☐Bi-racial/Multi-racial ☐ Black or African American ☐ Caucasian ☐ Native Hawaiian or other Pacific Islander ☐Unspecified ☐Other _________
Education Level:_________________ Name: _________________ Contact: _________________	Employment Status:_____________ Name: _________________ Contact: _________________	Military Status: ☐Active Duty ☐Veteran

Primary Adult Contact Information

Primary Phone: _______________	Secondary Phone: _______________	Email:________________________

Address: ____________________________City:__________State:____Zip:_______County:_______ ☐Permanent ☐Mailing

Address: ____________________________City:__________State:____Zip:_______County:_______ ☐Permanent ☐Mailing

Household Structure

Family Structure: ☐Single Parent/Person ☐Two Parent/Person Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Separated ☐Other ________	**Parent(s)/Guardian(s) Best Descriptor:** ☐Mother ☐Father ☐Parents ☐Grandparent(s) ☐Other Relative ☐Foster Parent(s) ☐Other __________	**Family Type:** ☐Single Parent/Female ☐Single Parent/Male ☐Two-Parent Household ☐Two-Parent Unmarried ☐Single Person ☐Two Adults (No Children) ☐Non-related Adults with Children ☐Multigenerational Household ☐Unknown/Not Reported ☐Other____________

Primary Adult (Participant) Eligibility Information

Disabled: ☐Unknown ☐Yes ☐No Mental Health Treatment: ☐Yes ☐No Medical Insurance: ☐Yes ☐No Type: _________		Income: $ __________ ☐Weekly ☐Bi-Weekly ☐Child Support $____ ☐Unemployment $____ ☐TANF $____ ☐SSI $____ ☐SSDI $____

Housing Information

# in Family (*Supported by Primary Caregiver's Income): _________ # in Household (*# of people in the home): _______	Current Housing: ☐Homeless ☐Rent ☐Own ☐Other _____ ☐Other Permanent Housing ☐Unknown/Not Reported Current Housing Date: ___________________	Previous Housing: ☐Homeless ☐Rent ☐Own ☐Other _____ ☐Other Permanent Housing ☐Unknown/Not Reported

COPA Family ID:	COPA Child ID:	Entered Date: Initials:

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Secondary Adult (Caregiver) Demographic Information

Name: ______________________________	☐ Male ☐Female ☐Other ________ DOB: ____________	SSN: __________________ ☐Random SSN Public Assistance: ☐TANF ☐WIC ☐FS/SNAP
Primary Language:________________ ☐Preferred Language	Primary Language:________________ ☐Preferred Language	Ethnicity: ☐Hispanic or Latino Race: ☐ American Indian or Alaska Native ☐Asian ☐Bi-racial/Multi-racial ☐ Black or African American ☐ Caucasian ☐ Native Hawaiian or other Pacific Islander ☐Unspecified ☐Other _________
Education Level:_________________ Name: _________________ Contact: _________________	Employment Status:______________ Name: _________________ Contact: _________________	Military Status: ☐Active Duty ☐Veteran

Secondary Adult Contact Information

Primary Phone: ______________	Secondary Phone: ______________	Email:________________________

Address: __________________________City:_________State:____Zip:_______County:_______ ☐Permanent ☐Mailing
Address: __________________________City:_________State:____Zip:_______County:_______ ☐Permanent ☐Mailing

Household Member Information

Name: ____________________ DOB: ______ Gender: ____ Employed: ☐Yes ☐No Education Level: ___________ Relation to Primary: _____
Name: ____________________ DOB: ______ Gender: ____ Employed: ☐Yes ☐No Education Level: ___________ Relation to Primary: ______
Name: ____________________ DOB: ______ Gender: ____ Employed: ☐Yes ☐No Education Level: ___________ Relation to Primary: ______
Name: ____________________ DOB: ______ Gender: ____ Employed: ☐Yes ☐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

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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: ______ ☐M ☐W ☐H Phone: ______ ☐M ☐W ☐H Phone: ______ ☐M ☐W ☐H	Relation to Child: ______ Language: ______ Address: ______	☐Joint Custodial Parent ☐Emergency Contact ☐Child can be released to this person ☐Emergency Closing Destination
Name: ______ Phone: ______ ☐M ☐W ☐H Phone: ______ ☐M ☐W ☐H Phone: ______ ☐M ☐W ☐H	Relation to Child: ______ Language: ______ Address: ______	☐Joint Custodial Parent ☐Emergency Contact ☐Child can be released to this person ☐Emergency Closing Destination
Name: ______ Phone: ______ ☐M ☐W ☐H Phone: ______ ☐M ☐W ☐H Phone: ______ ☐M ☐W ☐H	Relation to Child: ______ Language: ______ Address: ______	☐Joint Custodial Parent ☐Emergency Contact ☐Child can be released to this person ☐Emergency Closing Destination
Name: ______ Phone: ______ ☐M ☐W ☐H Phone: ______ ☐M ☐W ☐H Phone: ______ ☐M ☐W ☐H	Relation to Child: ______ Language: ______ Address: ______	☐Joint Custodial Parent ☐Emergency Contact ☐Child can be released to this person ☐Emergency Closing Destination
Name: ______ Phone: ______ ☐M ☐W ☐H Phone: ______ ☐M ☐W ☐H Phone: ______ ☐M ☐W ☐H	Relation to Child: ______ Language: ______ Address: ______	☐Joint Custodial Parent ☐Emergency Contact ☐Child can be released to this person ☐Emergency Closing Destination
Restricted Pick-Up		
Name: ______	Reason: ______	☐Court Order Effective Date: ______
Name: ______	Reason: ______	☐Court Order Effective Date: ______
Name: ______	Reason: ______	☐Court Order Effective Date: ______
Name: ______	Reason: ______	☐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

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Child Schedule

Please indicate what days your child will be **attending** on a regular basis.

Monday	Tuesday	Wednesday	Thursday	Friday
☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO

Notes:

Transportation

I will transport my child(ren) to LCC:	☐YES	☐NO
I give permission for my child(ren) to walk without supervision of Advantage Staff to LCC	☐YES	☐NO
I give permission for my child to take the designated RTS bus supervised by AASP staff to LCC	☐YES	☐NO

________________________________ Primary Caregiver Name (Print)

____ Primary Caregiver Signature & Date

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