

After School: Fall

After School: Spring

5th Quarter Summer Program

Schedule: _____ to _____

Referred by _____

Household Information

Family/Guardian name: _____ Date of Birth: _____

2nd - Family/Guardian name: _____ Date of Birth: _____

Address: _____

City: _____ State: IN Zip code: _____

Primary Phone: _____ Secondary Phone: _____

Email Address: _____

Employer's Name: _____

Employer's Phone: _____

Names and Ages of All Children in Your Household:

Please if enrolling child listed, and include all school information for those children only.

Name: _____ DOB: _____ Age: _____
Gender: _____ School: _____ Grade (current): _____ Teacher: _____

Name: _____ DOB: _____ Age: _____
Gender: _____ School: _____ Grade (current): _____ Teacher: _____

Name: _____ DOB: _____ Age: _____
Gender: _____ School: _____ Grade (current): _____ Teacher: _____

Name: _____ DOB: _____ Age: _____
Gender: _____ School: _____ Grade (current): _____ Teacher: _____

Emergency Contact and Authorized Pick up Information

In case of emergency, if family/guardian cannot be reached, the following may be contacted for pick up:

Name: _____ Name: _____

Address: _____ Address: _____

Phone Number: _____ Phone Number: _____

Email Address: _____ Email Address: _____

Relationship to Child(ren): _____ Relationship to Child(ren): _____

Additional Emergency Contact and Authorized Pick up Persons (optional):

Name: _____

Name: _____

Address: _____

Address: _____

Phone Number: _____

Phone Number: _____

Email Address: _____

Email Address: _____

Relationship to Child(ren): _____

Relationship to Child(ren): _____

Permissions for Lafayette Urban Ministry: Please initial next to your responses below

Media Releases

1. I give my permission to have Lafayette Urban Ministry and it's staff to use pictures or quotes from my child for informational or publicity purposes including, but not limited to, reproduction in newspapers or newsletters, websites, social media, pamphlets, or other promotional materials.
Yes _____ No _____
2. I give permission for my child to be identified by name in captions, quotes, or photographs used by Lafayette Urban Ministry as listed above.
Yes _____ No _____

_____ **Food Policy:** Snacks will be provided by LUM for all Youth Programs. **For 5th Quarter Summer program,** I understand that I am responsible for packing a lunch daily. I further understand that it is my responsibility to ensure the food arrives cold, preferably in an insulated bag with an ice pack due to limited refrigerator space.

_____ **Communicate with Teachers:** I give the listed school(s) and teacher(s) permission to pass on homework expectations and student information to the employees of the LUM After School Program.

_____ **Liability Waiver:** I understand that LUM endeavors to provide a safe and caring environment for the children in their care. I waive, release, and discharge from any and all liability, including but not limited to, liability arising for the negligence or fault of the LUM Board of Directors, employees, and volunteers, for my child's well-being, property, or action of any kind which may hereafter occur to my child during their participation in the LUM program. Charges and fees of medical services are not the responsibility of LUM and/or its staff. I, also, understand that LUM does not provide accident insurance and cannot assume responsibility of any injury to any participant(s) in its programs. I have read & understand the Liability Waiver; and I agree to the terms stated above.

_____ **Transportation Release:** I give permission for Lafayette Urban Ministry (LUM) to transport my child(ren) from their school to LUM. I further give permission for transportation for Field Trips during After School or 5th Quarter Summer Programming. I will be notified of field trips in advance.

_____ **Payment Expectations:** I have received a copy of Payment Expectations, and agree to pay the fees in advance: Daily (summer only) Weekly Biweekly Monthly (School year only)

_____ **Behavior Expectations:** I have received a copy of the Youth Programs Behavior Expectations, Please list additional requests, modifications, or suggestions for your child(ren):

Family Affirmation: I am the child(ren)'s legal guardian and have the authority to submit this form. All information in this Application Form is correct to the best of my knowledge.

Your Full name, please print: _____ Relationship to child(ren): _____

Signature: _____ Date: _____



PARENT'S NOTICE

State Form 49444 (R2 / 5-17)
FAMILY AND SOCIAL SERVICES ADMINISTRATION
OFFICE OF EARLY CHILDHOOD AND OUT-OF-SCHOOL LEARNING

I understand that this day care ministry is not licensed under the laws of Indiana. However, I understand that this day care ministry complies with the State rules concerning sanitation and fire safety for the primary use of the structure in which it is conducted. I understand that it is my responsibility to ensure that the nutritional and health needs of my child are met while my child is at the day care ministry.

Signature of Parent or Guardian

Name(s) of children enrolled

This notice does not absolve a day care ministry from liability for injury to a child while the child is at the day care ministry if the cause of the injury is negligence or intentional wrongdoing on the part of the day care ministry or an employee of the day care ministry.

Name of facility

Lafayette Urban Ministry After School and Summer Child Care

Address of facility (number and street, city, state, and ZIP code)

525 N. 4th St.

Lafayette, IN 47901

County

Tippecanoe

Lafayette Urban Ministry Youth Programs
Medical and Educational Needs Information

Please Complete one form for each child enrolled in LUM Youth Programs

Child's Name _____ Date of Birth: _____

Does your child have any learning difficulties? Yes _____ No _____
If yes, please describe: _____

Does your child have any diagnosed medical conditions? Yes _____ No _____
If yes, please describe: _____

Does your child take any medications: Yes _____ No _____
If yes, please list name, dosage, and time(s) given: _____

Will any medications need to be administered at our program? Yes _____ No _____
If yes, we need to have doctor permission to administer medication(s) on file.

Other Health Information

Child's Physician: _____ Phone #: _____

Do we have permission to speak to your child's doctor if needed? Yes _____ No _____

Has your child seen the doctor in the last 6 months? Yes _____ No _____

If yes, list date: _____

Child's general health is: Good _____ Fair _____ Poor _____

Does your child have up to date shot records? Yes _____ No _____

***A copy of your child's shot records is required for entrance into the program.**

Is your child:

Yes _____ No _____ diagnosed with a learning or cognitive disability

Yes _____ No _____ diagnosed with an emotional disability or mental health condition

Yes _____ No _____ diagnosed with a physical disability

Yes _____ No _____ have any allergies **(We may require medical documentation)**

Yes _____ No _____ required to be offered a special diet **(We may require medical documentation)**

Yes _____ No _____ diagnosed with ADD or ADHD

Yes _____ No _____ diagnosed with Autism Spectrum Disorder

Yes _____ No _____ have an Individualized Education Plan (IEP) **(We require a copy for our records)**

*If you have answered yes to any of the above, please specifically describe including required medications: _____

Legal Guardian Signature (required)

Date