21ST CCLC/Shelby Public Schools

525 N. State Street • Shelby • MI • 49455 • (231) 861-4521

Enrollment Application

For Provider Use Only:
Date of Admission: _____ Date of Dismissal: _____

(Please complete all information. Incomplete forms will be returned for completion. Enter "None" for items that do not apply.)

Student Name: _____ **Sex:** _____ **Date of Birth:** _____

School: _____ **Teacher Name:** _____ **Grade:** _____ **Bus#:** _____

Home Address: _____ **City:** _____ **Zip:** _____

Mailing Address: _____ **City:** _____ **Zip:** _____

Father / Legal Guardian's Name:		Home Phone: ( )	Mother / Legal Guardian's Name:		Home Phone: ( )
Home Address (if not child's address)		Cell Phone: ( )	Home Address (if not child's address)		Cell Phone: ( )
City:	State:	Zip:	City:	State:	Zip:
Email Address (optional):			Email Address (optional):		
Employer Name:		Work Phone: ( )	Employer Name:		Work Phone: ( )

Child Lives With: Both Parents Mother Father Other Person: _____

Language spoken in home: English Spanish Both Other: _____

Student's Race / Ethnicity: African American Caucasian / White Hispanic
Asian Native American Multi-Racial

Other children in the home:			
Name: Age: Grade:		Name: Age: Grade:	

Emergency Contacts:			
Name:	Phone #:	Name:	Phone #:
Names and Phone Numbers of whom child may be released:			
Name:	Phone #:	Name:	Phone #:
Name:	Phone #:	Name:	Phone #:

Transportation: Pick-up Walk Bus

Daycare Name / Contact Name: _____

Daycare Phone#: _____ **Daycare Address:** _____

The ASPIRE program and all publications are funded by the
21st Century Community Learning Center Grant.

Health History Information: (Check any items below that child is / has experienced. Please provide further explanation below.)

- ☐ Allergy to bee stings
- ☐ Allergy to medication
- ☐ Allergy to foods
- ☐ Arthritis
- ☐ Asthma
- ☐ Back condition
- ☐ Head Injury
- ☐ Other health issues _____
- ☐ Chronic illness
- ☐ Developmental disability
- ☐ Diabetes
- ☐ Epilepsy / Seizures
- ☐ Fainting spells
- ☐ Frequent colds
- ☐ Strokes
- ☐ Hemophilia
- ☐ Hypertension
- ☐ Kidney problems
- ☐ Lung disease
- ☐ Rheumatic fever
- ☐ Balance problems
- ☐ Heart disease / defect

If any of the above boxes are checked, please explain: _____

Does the student have any sensory, cognitive, or physical disabilities? ☐ Yes ☐ No

If yes explain: _____

Does the student have any mobility impairment? ☐ Yes ☐ No If yes, explain: _____

Has the student been treated or hospitalized in the last 24 months? ☐ Yes ☐ No

If yes, for what injury or illness? _____

Medications Student is taking: _____

Allergic Reactions: _____

Does allergy require an epi-pen? ☐ Yes ☐ No If yes, when was it last administered? _____

Family Physician: _____ Phone # _____

By signing this I certify that my child, _____, is in good health. If they have any activity restrictions, they have been noted on this form. My child's immunizations are up-to-date and their immunization record or appropriate waiver is on file with my child's school. I give permission to ASPIRE, licensed by the Department of Human Services to secure emergency medical and / or emergency surgical treatment for the above named minor child while in care.

Signature of Parent: _____ Date: _____

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