

Application Information

2010-2011

Child's Name: _____ Date (of application): _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

City State Zip Code

Home Phone: (____) _____ Email Address: _____@_____

Date of Birth: ____/____/____ Age: _____ Grade: _____ School: _____

Classroom Teacher: _____

Race/Ethnicity: Caucasian African American Hispanic/ Latino Asian
 Native Hawaiian/ Other Pacific Islander Native American or Alaska Native

Gender: Male Female

How did you hear about Jane Boyd: Family Friends Website TV Agency referral other:

How many years has your child attended Jane Boyd Programs: _____

Parent/ Primary Guardian Information

Primary Guardian (s) Name Residing with Child:

Primary Guardian:

First: _____

First: _____

Last: _____

Last: _____

Relationship to Child: _____

Relationship to Child: _____

Home Address: _____

Home Address: _____

Place of Employment: _____

Place of Employment: _____

Work Phone: (____) _____

Work Phone: (____) _____

Home Phone: (____) _____

Home Phone: (____) _____

Cell Phone: (____) _____

Cell Phone: (____) _____

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Alternate Pick Up/Emergency Contact Information

Please list three persons that are emergency contacts and/or authorized to pick your child up in the event you are unable to do so.

Full name: _____ Relationship: _____

Work Phone: (____) _____ Cell Phone: (____) _____ Home Phone: (____) _____

Home Address: _____
Street Address Apt/Unit# City/State

Full name: _____ Relationship: _____

Work Phone: (____) _____ Cell Phone: (____) _____ Home Phone: (____) _____

Home Address: _____
Street Address Apt/Unit# City/State

Full name: _____ Relationship: _____

Work Phone: (____) _____ Cell Phone: (____) _____ Home Phone: (____) _____

Home Address: _____
Street Address Apt/Unit# City/State

Medical Information

In the event that my child may require emergency medical, dental and/or surgical care while I am unable to be reached, I hereby give my consent to medical, dental, and/or surgical treatment. I agree to pay all costs and fees contingent on any emergency treatment for my child as secured or authorized under this consent. This consent will be in effect until services are discontinued from Jane Boyd After School Program 2010-2011.

Hospital/ Clinic Preference: _____

Physician's Name: _____ Phone Number: (____) _____

Dentist's Name: _____ Phone Number: (____) _____

Insurance Company: _____ Policy Number: _____

Current Medications/ Dosage: _____

Allergies/Special Health Conditions: _____

Parent/ Guardian Questionnaire

1. Primary Parent Name: _____ Circle: Mother/Father

Marital Status: Single Married Divorced Widowed Paramour

Current Employment: Employed Full-Time Employed Part-Time Unemployed

Ethnicity: Caucasian African American Hispanic/ Latino Asian

Native Hawaiian/ Other Pacific Islander Native American or Alaska Native

Primary Source of Income: Employment Child Support Public Assistance

Other: _____

2. Parent/Guardian Name: _____ Circle: Mother/Father

Marital Status: Single Married Divorced Widowed Paramour

Current Employment: Employed Full-Time Employed Part-Time Unemployed

Ethnicity: Caucasian African American Hispanic/ Latino Asian

Native Hawaiian/ Other Pacific Islander Native American or Alaska Native

Primary Source of Income: Employment Child Support Public Assistance

Other: _____

Household Income: Please circle your family's annual income (closest) under the column that indicates the number of people in your household.

Number of Family Members	One	Two	Three	Four	Five	Six	Seven	Eight
Yearly Income	\$14,100	\$16,100	\$18,400	\$20,150	\$21,750	\$23,350	\$24,950	\$26,550
	\$23,500	\$26,850	\$30,200	\$33,550	\$36,250	\$38,900	\$41,600	\$44,300
	\$28,200	\$32,220	\$36,240	\$40,260	\$43,680	\$46,680	\$49,920	\$53,160
	\$37,600	\$42,950	\$48,300	\$53,700	\$57,950	\$62,250	\$66,550	\$70,850

Child/ Family Services

Please check all services the child or parent/ guardian receives on behalf of the child:

- Free school breakfast/lunch Reduced school breakfast/ lunch Special Education/IEP
- SSI (Disability) FIP Medicaid Food Stamps Housing Assistance
- Foster Care Services Counseling/Mental Health Services: (please explain): _____

Any other information that will help us work well with your child: _____

Please indicate numbers for the following:

- ____ Number of children in the family
- ____ Number of children in Jane Boyd Afterschool Program (names): _____
- ____ Number of family members under 5 years old
- ____ Number of family members 5 to 12 years old
- ____ Number of family members 13 to 17 years old
- ____ Numbers of family members 18 to 29 years old
- ____ Number of family members 30 to 60 years old
- ____ Number of family members over 61 years old
- ____ Number of family members currently employed
- ____ Number of family members currently employed full time
- ____ Number of family members employed part time
- ____ Number of family members receiving SSI
- ____ Number of family members receiving free breakfast/ lunch
- ____ Number of family members receiving reduced breakfast/ lunch

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Program Releases

Transportation- Field Trips

Jane Boyd regularly takes community field trips. The program staff will make every effort to notify you in advance of these field trips but will not exclude your child from a field trip if this contact cannot be made. You may, at time, limit or discontinue your child's participation in community field trips with written notice to the Program Director.

Parent Signature: _____ Date: _____

Photographs/ Videotape

Jane Boyd may photograph or videotape my child's activities. I authorize Jane Boyd, without limitation to copy, publish and exhibit such photographs or videotapes for the sole purpose of reporting or promoting Jane Boyd Community House. I waive all rights or claims I may have against the organization and/or its subsidiaries or assignees related to the above photographs and videotapes.

Parent Signature: _____ Date: _____

Financial Commitment

-----Office use only-----

Proof of Household income: Pay stub Statement W-4 Bank Statement

Total Gross income: Monthly: \$ _____ Annually: \$ _____

Number of children attending: _____

Yearly After School Fee: \$ _____

The responsible party (parties) below agree the above amount is the accurate yearly fee for their child (ren) to attend Jane Boyd After School Program. The party (parties) also accepts the responsibility of providing timely payments to Jane Boyd.

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____