K's
PRECIOUS CARE

KPC Before/After/ Summer School Application

Name of Child:	Date of Birth:	
Current Address:	City:	Phone:
Name of Parents:		
Email:	Parents Are: M D SP W S	

Employment Information

Mother Employer/School:	Hours:
Father Employer/School:	Hours:

Care Information

Date Program Needed:	Date Program Approved to Begin:
Program Choice: Before/After School/ Evening /Summer	Hours Needed:
Transportation needed? Y N	Suggested Programs:

Payment Information

How Will You Be Making Payments	Cash - FREE	DHS - FREE	Other: FREE for OST

Other Information

Will Your Child Participate In Food Program Y N		
Allergies:	Milk Preference:	Peanut Allergy:
Seasonal Allergies:	Type:	Meds/Treatment:

Siblings/Referrals

Name:	Age:	School:
Name:	Age:	School:

I REALIZE THIS IS A PRE-APPLICATION FOR K'S PRECIOUS CARE LEARNING CENTER AND IS NOT HELD ACCOUNTABLE TO PAY TO HOLD A SLOT IN CHILDCARE. I ALSO REALIZE THAT I WILL BE CALLED FOR AN INTERVIEW WHEN CONTACTED BY THE FACILITY.

Parent Signature:	Date:
Director Signature:	Date:

MiLEAP Michigan Department of Lifelong Education, Advancement, and Potential

MASP Michigan Afterschool Partnership

32N OUT-OF-SCHOOL TIME PROGRAM ENROLLMENT FORM

Program * KPC & MMCA ☐ Before School ☐ After School ☑ Summer

STUDENT INFORMATION

Student Name *

Address

Zip Code *

Phone Number **Date of Birth *** (mm/dd/yyyy)

School Name **Grade Level ***

Gender * ○ Female ○ Male ○ Nonbinary/Some other gender ○ Prefer not to disclose

Race/Ethnicity * (check all that apply)

- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ Hispanic/Latino
- ☐ Middle Eastern/North African
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Prefer not to disclose

Transportation Home (check all that apply)

☐ Pick Up/Drive ☐ Walk ☐ Bus ☐ Other:

Are siblings enrolled? ○ No ○ Yes

Siblings' Names:

SCHOOL CONTACT INFORMATION (FOR TEACHER SURVEY)

Contact Name *

Contact Email *

Contact Type * ○ Teacher ○ Counselor

PARENT/LEGAL GUARDIAN CONTACT INFORMATION

PARENT/GUARDIAN 1 ☐ Authorized to Pick Up

Name *

Relationship to Student*

Phone Number*

Email *

Address

Zip Code

PARENT/GUARDIAN 2 ☐ Authorized to Pick Up

Name *

Relationship to Student*

Phone Number*

Email *

Address

Zip Code

EMERGENCY CONTACTS (AUTHORIZED FOR PICK UP IF NEEDED)

EMERGENCY CONTACT #1

Name

Relationship to Student

Phone Number 1

Phone Number 2

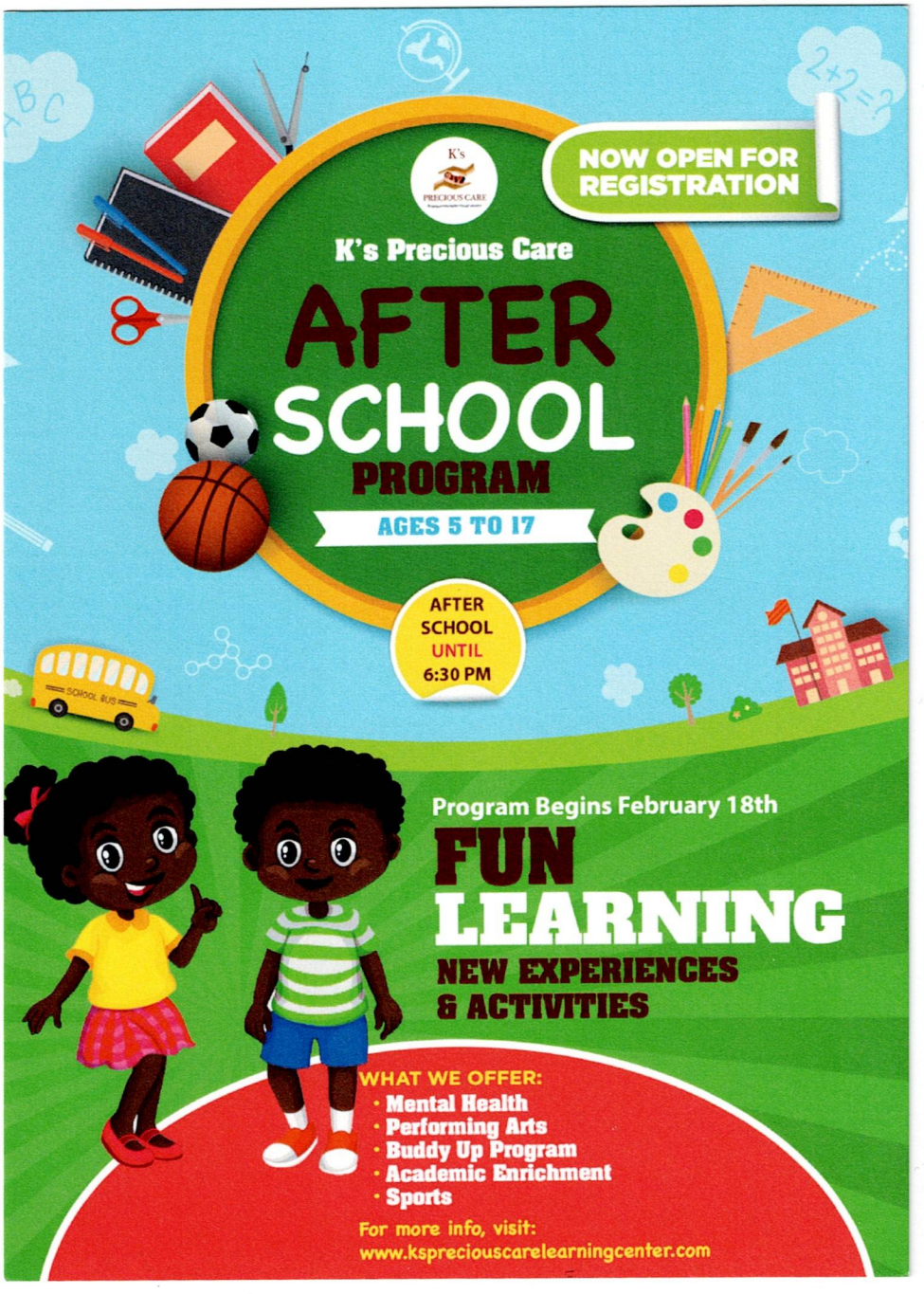
EMERGENCY CONTACT #2

Name

Relationship to Student

Phone Number 1

Phone Number 2


K's
PRECIOUS CARE
NOW OPEN FOR REGISTRATION
K's Precious Care
AFTER SCHOOL PROGRAM
AGES 5 TO 17
AFTER SCHOOL UNTIL 6:30 PM
Program Begins February 18th
FUN LEARNING
NEW EXPERIENCES & ACTIVITIES
WHAT WE OFFER:
• Mental Health
• Performing Arts
• Buddy Up Program
• Academic Enrichment
• Sports
For more info, visit:
www.kspreciouscarelearningcenter.com

AFTERSCHOOL

PROGRAM ACTIVITY'S

"MENTAL HEALTH FOR OUR YOUTH"
COORDINATED BY OUR MENTAL HEALTH SPECIALIST JAZMIN GUY.

"BUDDY UP PROGRAM"
OLDER CHILDREN 13 AND UP WILL MENTOR YOUNGER CHILDREN 12 AND UNDER. THEY WILL "BUDDY UP" ON TUESDAYS AND FRIDAYS FOR SPECIAL ACTIVITIES SUCH AS COOKING, MOVIES, SKATING, GARDENING, AND FUN RECREATIONAL ACTIVITIES.

"PERFORMING ARTS" FEATURING TRANSCENDENCE PERFORMING ARTS CENTER, INC (TPAC)
WHERE CHILDREN WILL MEET FROM 5 PM TO 6:30 PM TO PRACTICE ACTIVITIES BUT NOT LIMITED TO: THEATER ARTS, VOCAL ARTS, DANCE, INSTRUMENTAL TRAINING, AND VIDEOGRAPHY.

"SPORTS-BASKETBALL TECHNIQUES"
TAUGHT BY OUR OWN LANSING COMMUNITY COLLEGE BASKETBALL COACH, MIKE INGRAM

SUMMER CAMP WILL BEGIN JUNE 16 TH OFFERING THESE SAME WORKSHOPS WITH A SHOWCASE PERFORMANCE IN AUGUST!

THE 32N OUT-OF-SCHOOL TIME PROGRAM (MILEAP) PROVIDES FUNDS FOR OUR 2024 SUMMERCAMP

CONTACT MS K AS SOON AS POSSIBLE AT (517)706-9480 OR BY EMAIL AT:
KSPRECIOUSCARE@GMAIL.COM

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32N OUT-OF-SCHOOL TIME PROGRAM ENROLLMENT FORM

HEALTH AND MEDICAL INFORMATION

Please Mark Below if Student Has Needs Related to (check all that apply):

☐ Allergies ☐ Asthma ☐ Diabetes ☐ Hearing Impairment ☐ Heart Troubles ☐ Learning Disability

☐ Physical Limitation ☐ Seizures ☐ Vision Problems ☐ Other: _____

Food Allergies: _____ **Allergic to Bees?** ○ Yes ○ No ○ I don't know

Any other health concerns we should know about? _____

Name and Phone Number of Student's Physician/Health Clinic _____

Preferred Hospital for Medical Treatment _____

PARENT/LEGAL GUARDIAN CONSENT AND AUTHORIZATIONS

This program receives funding from the State of Michigan to serve your child. Michigan State University and Public Policy Associates are contracted to evaluate program quality and impacts. **By enrolling my child in this program, I agree that the program will share the asterisked * attendance and demographic information with the contracted evaluators. All data will be kept confidential.**

Read each statement and write your initials to indicate agreement:

_____ Enrollment in the program is voluntary. I understand that regular attendance is expected.

_____ I have received a copy of the family handbook. I agree to the program's policies. I will tell the program if my contact information changes.

_____ I understand that the program's playground equipment may not fully comply with licensing standards.

_____ I give my permission for my child to attend field trips. Program staff will give me information about field trips in advance. I agree that the program is not responsible if my child has a medical emergency during a field trip.

_____ I have told staff about any restrictions to my child's activities.

_____ My child's immunization records are up to date. I agree to provide the immunization record or appropriate waiver with the program upon request.

_____ If my child needs medication during the program, I will give the site manager (a) a medication authorization form and (b) the medication in its original prescription bottle.

_____ I give the staff permission to get emergency medical treatment for my child. Emergency treatment may include surgery.

_____ I give the staff permission to apply insect repellent, sunscreen, and antibacterial cleanser to my child's skin when needed. I can ask for specific information about these products.

Student Name _____ **Parent/Guardian Name** _____

Date (mm/dd/yyyy) _____ **Parent/Guardian Signature** _____

INTERNAL USE ONLY ☐ **Asterisked* Data Entered in EZReports**

Admission Date * _____ **Discharge Date *** _____