Youth Services
Program Registration Form

CIRCLE THE PROGRAM YOU ARE REGISTERING FOR:

Off the Street Inspire to Achieve Mentoring After-School Action Program

S.T.A.R Summer Literacy Program C.O.P.E Case Management for Youth

STUDENT INFORMATION

Student Name: _____ Gender: M☐ F☐ NB☐

Address: _____ Race/Ethnicity: _____

Date of Birth: _____ School: _____ Grade: ____

PARENT/GUARDIAN 1

Name: _____ Relationship to Student: _____

Phone: _____ Email: _____

PARENT/GUARDIAN 2

Name: _____ Relationship to Student: _____

Phone: _____ Email: _____

HEALTH & MEDICAL INFORMATION

Please mark if student has needs related to (check all that apply):

☐ Allergies ☐ Asthma ☐ Diabetes ☐ Hearing Impairment ☐ Heart troubles ☐ Seizures

☐ Learning Disability ☐ Physical Limitation ☐ Vision Problems ☐ Other: _____

Please explain: _____

_____

PARENT/LEGAL GUARDIAN CONSENT & AUTHORIZATION

Our programs receive 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 attendance and demographic information with the contracted evaluators. All data will be kept confidential.

I understand that ECAC and all its associates; staff, volunteers, etc. are not liable for any property or person participating in any component or activity associated with this program. If all efforts to contact the emergency contact persons(s) identified above are unsuccessful, I hereby give the ECAC staff permission to seek emergency medical attention for my child. ECAC staff may also administer medication prescribed for my child.

Student Name: _____ Date: _____

Parent/Guardian Name: _____ Signature: _____

Once form is complete please email to ecacclansing@gmail.com