



2019-20 LifeWise STL After School Program Application

Please return forms and documentation to this location. Incomplete applications will not be accepted.

Por favor devuelva este formulario y documentos adjuntos a una de las siguientes localidades. Paquetes de aplicación incompletos, no serán aceptados.

LifeWise STL
1321 South 11th Street, St. Louis, MO 63104
Misti Johnson; 314-627-1241 (K-8)

OFFICE USE ONLY
DATE RECEIVED: _____
START DATE: _____
TRANSPORTATION: Yes or No
PICK UP:
DROP-OFF:



Child Information:

First Name:	Middle Initial:	Last Name:	
Has your child attended After School before? (Please Check)		Yes _____ No _____	
Address:			
City:	State:	Zip Code:	
Birth Date:	Age:	Gender:	Race/Ethnicity:
Shirt Size (Please Circle): XS S M L XL Youth _____ Adult _____			

School History: *Attach most recent report card

School:	Grade Level:
Does your child receive Free or Reduced Lunch at school?	Yes _____ No _____
Has your child ever participated in Special Education or had a 504 plan? IEP? Yes, 504, IEP _____ No _____	
Does your child have a Behavior Plan?	Yes _____ No _____

Comments on Child's Development:

What are some strategies LifeWise STL can use to best support your child's learning throughout the program? (ex: positive reinforcement, small groups)

LifeWise STL does offer therapeutic/behavioral support through individual therapy and social emotional skills groups. If interested in the possibility of individual therapy for your child/the child for whom you are serving as legal guardian, please see Authorizations-Observation/Referral below to opt in.

Medical History (Please Check): *Current Physical and Immunizations Record Required

ADD _____ ADHD _____ Autism _____ Asperger's _____
Eyeglasses/Contacts _____ Hearing Aid _____
Epilepsy _____ Diabetes _____ Sickle Cell _____ Asthma _____
Allergies (Please List):
Dietary Restrictions (Please List):
Medications (Please List):
Health Problems (List):
If your child has asthma or food allergies, we must have an inhaler and/or Epipen on site before your child can begin the program.
Does your child see a dentist at least once a year? Yes _____ No _____
<input type="radio"/> My child is in good health, is able to participate in program activities, and has no special health or medical requirements.
<input type="radio"/> My child is able to participate in program activities, but has special health or medical requirements as listed below.

Parent/Legal Guardian Signature _____ Date _____



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Child's First Name:	Last Name:	Age:
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Head of Household (Parent/Guardian):

First Name:		Last Name:	
Age:	Gender:	Race/Ethnicity:	DOB:
Address:			
City:		State:	Zip Code:
Home Phone: ()		Cell Phone: ()	
Work Phone: ()		Email Address:	
Currently Employed? Yes _____ No _____		Currently in School? Yes _____ No _____	
Work Schedule:		School Schedule:	
Employer Name:			
Employer Address:			
City:		State:	Zip Code:

Other Parent/Guardian/Emergency Contact:

First Name:		Last Name:	
Age:	Gender:	Race/Ethnicity:	DOB:
Relationship to Child:			
Address:			
City:		State:	Zip Code:
Home Phone: ()		Cell Phone: ()	
Work Phone: ()		Email Address:	
Employer:			
Currently Employed? Yes _____ No _____		Currently in School? Yes _____ No _____	
Work Schedule:		School Schedule:	
Employer Name:			
Employer Address:			
City:		State:	Zip Code:

Household Information: LifeWise STL receives public funding and is often required to provide basic information about membership households. Please help us continue receiving these funds by providing information about your household.

Family Annual Income (Please Circle):	Living Arrangements (Please Circle):	Sources of Income:
\$0 - \$9,999	Both Parents	Child Support
\$10,000 - \$14,999	Mother Only	Food Stamps
\$15,000 - \$19,999	Father Only	Medicaid
\$20,000 - \$29,999	Both Grandparents	TANF
\$30,000 - \$49,999	One Grandparent	Unemployment
\$50,000 - \$99,999	Only Guardian	SSI
	Other:	SSDI
		Daycare Voucher
		Veterans Compensation
		Other:
Total Household Size:	Total in Household Under 18:	

Parent/Legal Guardian Signature _____ Date _____



Child's First Name:	Last Name:	Age:
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Authorizations

Media:

I give permission to allow LifeWise STL and its partners the unlimited right to use photos, videos, direct quotes and/or audio clips that they have of my child participating in LifeWise STL programs or events.

Yes _____ No _____

Surveys:

I give permission for my child to participate in program surveys and/or assessment. Surveys may ask about my child's demographics, child's performance in school, child's friends, child's neighborhood, and child's experience in programs; in addition to participant's knowledge, skills, coping, and/or abilities in the areas of health, nutrition, science, technology, engineering, art and literacy. All surveys are confidential; your child's name will not appear on the survey. I understand that I can withdraw consent at any time by submitting a written signed statement.

Yes _____ No _____

Assessments/Tests:

I give permission for my child to participate in testing that will evaluate literacy skills (such as fluency and comprehension) of my child. I understand that I have access to results of literacy assessments, and that results will help LifeWise STL determine if any gains in literacy occurred.

Yes _____ No _____

Lost, Stolen and/or Damaged Possessions:

I have been informed that my child should not bring valuable possessions (such as electronic devices) to LifeWise STL. I understand that LifeWise STL is NOT responsible for replacing any property that is lost, stolen and/or damaged while attending programming.

Yes _____ No _____

Release Information

I give my consent to school counselors, teachers, nurses, social workers, and all others working with my child to release records to LifeWise STL and its partner agencies, including information on behavior at school, grades, test scores, notification of suspensions, medical records, etc. I understand that all information given to LifeWise STL and its partner agencies will be restricted and confidential.

Yes _____ No _____

Observation/Referral:

I give permission for my child to be referred to assessment and possible therapeutic treatment based on behavioral observation (i.e. observed changes in behavior, increases in externalizing or internalizing actions). I understand that I will be further notified upon referral about the process and possible continued treatment. I further understand that I have the right to refuse further action upon notice of referral.

Yes _____ No _____

Permission for Participant:

Can your child swim? _____ Yes, swims very well _____ Yes, but only knows basic swimming _____ No

Do you give permission for your child (12 years or older) to leave unattended? Yes _____ No _____



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AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I UNDERSTAND THAT I WILL BE NOTIFIED AT ONCE IN CASE OF AN EMERGENCY WITH MY CHILD, AND I WILL MAKE ARRANGEMENTS FOR MEDICAL CARE OF MY CHILD WITH THE PHYSICIAN OR HOSPITAL OF MY CHOICE.

IF I CANNOT BE REACHED TO MAKE NECESSARY ARRANGEMENTS, OR IN A CRITICAL EMERGENCY REQUIRING MEDICAL CARE, I AUTHORIZE

LifeWise STL

DAY CARE PROVIDER OR HOME PROVIDER

TO CONTACT THE FOLLOWING:

PHYSICIAN OR CLINIC

NAME	TELEPHONE NUMBER
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PREFERRED HOSPITAL

NAME	TELEPHONE NUMBER
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ACKNOWLEDGEMENTS

A	I HAVE RECEIVED A COPY OF THIS FACILITY'S POLICIES PERTAINING TO THE ADMISSION, CARE AND DISCHARGE OF CHILDREN.	PARENT/GUARDIAN INITIALS
B	I HAVE BEEN INFORMED THAT A COPY OF THE LICENSING RULES FOR CHILD CARE HOMES OR THE LICENSING RULES FOR GROUP CHILD CARE HOMES AND CENTERS IS AVAILABLE AT THIS FACILITY FOR REVIEW.	PARENT/GUARDIAN INITIALS
C	THE PROVIDER AND I HAVE AGREED ON A PLAN FOR CONTINUING COMMUNICATION REGARDING MY CHILD'S DEVELOPMENT, BEHAVIOR, AND INDIVIDUAL NEEDS.	PARENT/GUARDIAN INITIALS
D	WHEN MY CHILD IS ILL, I UNDERSTAND AND AGREE THAT S/HE MAY NOT BE ACCEPTED FOR CARE OR REMAIN IN CARE.	PARENT/GUARDIAN INITIALS
E	I UNDERSTAND THAT, BEFORE THE FIRST DAY OF ATTENDANCE BY MY CHILD, I WILL PROVIDE PROOF OF COMPLETED AGE-APPROPRIATE IMMUNIZATIONS OR EXEMPTION FROM IMMUNIZATIONS.	PARENT/GUARDIAN INITIALS
F	I <input type="checkbox"/> DO <input type="checkbox"/> DO NOT GIVE PERMISSION FOR FIELD TRIPS/EXCURSIONS. I UNDERSTAND I WILL BE NOTIFIED IN ADVANCE WHEN THEY ARE PLANNED.	PARENT/GUARDIAN INITIALS
G	I <input type="checkbox"/> DO <input type="checkbox"/> DO NOT GIVE PERMISSION FOR THE FACILITY TO TRANSPORT MY CHILD.	PARENT/GUARDIAN INITIALS
H	I HAVE BEEN NOTIFIED THAT I MAY REQUEST NOTICE AT INITIAL ENROLLMENT OR ANY TIME THERE AFTER WHETHER THERE ARE CHILDREN CURRENTLY ENROLLED IN OR ATTENDING THE FACILITY FOR WHOM AN IMMUNIZATION EXEMPTION HAS BEEN FILED.	PARENT/GUARDIAN INITIALS

PARENT'S/GUARDIAN'S SIGNATURE	DATE
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CACFP REQUIREMENT	FIRST ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
	SECOND ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE

Parent/Legal Guardian Signature _____ Date _____



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Child's First Name:	Last Name:	Age:
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Pick-Up/Emergency Contact Information (Please include yourself on this form): * Must be 18 years or older

<input type="radio"/> Pick Up	<input type="radio"/> Walk Home	<input type="radio"/> Van	<input type="radio"/> Other:
Authorized Person #1 (Parent):			
Relationship to Child:			
Address:			
City:	State:	Zip Code:	
Home Phone: ()	Cell Phone: ()		
Authorized Person #2:			
Relationship to Child:			
Address:			
City:	State:	Zip Code:	
Home Phone: ()	Cell Phone: ()		
Authorized Person #3:			
Relationship to Child:			
Address:			
City:	State:	Zip Code:	
Home Phone: ()	Cell Phone: ()		

Parent/Legal Guardian Signature _____ Date _____