



To the Family of \_\_\_\_\_

Minneapolis Public Schools would like to invite your child to participate in Extended Day Programming. This exciting program will give your child the opportunity to accelerate their academic skills in math, reading, science, and more. Class sizes will be small and fun, and students will participate in enrichment classes as well as academic classes.

- **Schedule:**
- **Location:**
- **Meals:** Snack included for all students
- **Transportation:** Included for eligible students
- **Cost:** Free!

If you are interested in having your child participate in Extended Day Programming, please complete the registration information below and return the form to your school office as soon as possible. Once your child is enrolled, you will receive bus stop times and locations. If you have any questions or concerns, please don't hesitate to contact the school office. We look forward to helping your child continue their academic growth during Extended Day Programming.

Address: \_\_\_\_\_

Room: \_\_\_\_\_

Student ID: \_\_\_\_\_

Grade: \_\_\_\_\_

Corrected Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Corrected Phone: \_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_

EMERGENCY CONTACT PHONE: \_\_\_\_\_

**PLEASE PRINT CLEARLY TO ENSURE A SAFE BUS STOP FOR YOUR STUDENT**

**PM Drop-Off Address**

Mark One Box:     This is correct     No bus needed     The correct address is:

DAYS:  Mon  Tues  Weds  Thurs  VARIES

Alternate PM Drop-Off Address and Phone:

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

DAYS:  Mon  Tues  Weds  Thurs  VARIES

**MPS SCHOOL HEALTH SERVICES ARE NOT AVAILABLE DURING AFTER SCHOOL PROGRAMS.** After school programming is not linked with the school health services office. It does not have access to school records (medical information, health plans, IEPs, Section 504 plans, etc.). Parents/guardians are responsible for notifying the On-site Coordinator of any special needs or medical conditions that impact their child's health, well-being, or involvement in activities. A conference with the family may be requested in order to determine what reasonable accommodations should be provided. If prescribed or over-the-counter medication must be given while a child is attending after school programming, parents/guardians must complete an authorization form before any medicine will be dispensed. Medication must be in its original packaging or prescription bottle. All medication will be stored on-site in a locked cabinet. *Medication is not accessible from the school nurse's office.*

Does your child have any medical or special needs (i.e. allergies, asthma, learning disability or medical condition)?

Yes  No If Yes, please specify: \_\_\_\_\_

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Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Membership Form

**BOYS & GIRLS CLUBS**  
OF THE TWIN CITIES

To enroll a child, a parent must complete this form and pay the \$5 membership fee.

Staff Use Only:	
Card #:	_____
Paid:	_____
Date Entered:	_____
Staff:	_____
GREAT FUTURES START	

ALL INFORMATION IS KEPT PRIVATE

### MEMBER INFORMATION (Please Print)

First Name	Middle Name	Last Name	Gender
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female
Birthdate	Cell Phone	<input type="checkbox"/> Asian / Pacific Islander <input type="checkbox"/> Caucasian <input type="checkbox"/> American Indian <input type="checkbox"/> African <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> African American <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other	
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>		
School ID #	School	Grade	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

### HEAD OF HOUSEHOLD / CUSTODIAL PARENT or GUARDIAN (Please Print)

First Name	Last Name	Relation to Member	Gender
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address	Employer	Household Income	
Address:	<input type="text"/>	<input type="checkbox"/> \$9,999 or less	
City:                      State:                      Zip:		<input type="checkbox"/> \$10,000 - \$14,999	
Phone Number(s)	Phone Type	Does your child qualify for free or reduced lunch?  <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> \$15,000 - \$23,999
(    ) -	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		<input type="checkbox"/> \$24,000 - \$34,999
(    ) -	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		<input type="checkbox"/> \$35,000 - \$49,999
Email Address: _____	Household Size _____		<input type="checkbox"/> \$50,000 and over

### OTHER PARENT OR GUARDIAN (Please Print)

First Name	Last Name	Relation to Member	Gender
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (if different from above):		Employer	
Address:		<input type="text"/>	
City:                      State:                      Zip:			
Phone Number(s)	Phone Type	Additional Phone Number	Phone Type
(    ) -	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	(    ) -	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
Email Address: _____			

### FAMILY SETTING

<input type="checkbox"/> Both Parents	<input type="checkbox"/> Father Only	<input type="checkbox"/> Mother Only	<input type="checkbox"/> Foster Parent(s)	<input type="checkbox"/> Grandparent(s)
<input type="checkbox"/> Guardian(s)	<input type="checkbox"/> Parent/Step-Parent	<input type="checkbox"/> Relative	<input type="checkbox"/> Parent/Domestic Partner	

### GENERAL ASSISTANCE (Please check all that apply)

<input type="checkbox"/> Veterans Compensation	<input type="checkbox"/> Day Care Voucher	<input type="checkbox"/> Medicaid	<input type="checkbox"/> TANF
<input type="checkbox"/> Food Stamps	<input type="checkbox"/> General Assistance	<input type="checkbox"/> SSDI	<input type="checkbox"/> SSI

**MEMBER MEDICAL INFORMATION** (Please Print)

Insurance Company		Medications	
		Medication:	Purpose:
Insurance Policy Number		Medication:	Purpose:
		Medication:	Purpose:
Physician	Physician Phone	Disabilities:	
Hospital	Hospital Phone	Medical Issues / Allergies:	

**EMERGENCY CONTACT OTHER THAN PARENT/GUARDIAN** (Please Print)

1.) First Name	Last Name	2.) First Name	Last Name
Phone Number(s)	Phone Type	Phone Number(s)	Phone Type
( ) -	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	( ) -	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
( ) -	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	( ) -	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
Relationship to member: _____		Relationship to member: _____	

The Club also uses the following information to learn more about your child.

Please check one item from each group below.

Single Parent Household	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parent in Military	<input type="checkbox"/> Yes <input type="checkbox"/> No
Qualifies for Free & Reduced Lunch	<input type="checkbox"/> Yes <input type="checkbox"/> No	Incarcerated Parent	<input type="checkbox"/> Yes <input type="checkbox"/> No
Public Housing Resident	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**TERMS OF AGREEMENT**

- ~ I have explained the rules to my son/daughter and agree that the Club will not be responsible for any accident to my child while on the Club premises or while engaged in any of its activities away from the site.
- ~ I am aware that it is my responsibility to notify the Club of any changes to mine or my child's contact, medical or other membership information.
- ~ I have completed this application, understand the rules and policies of the Club, and request that my son/daughter be admitted into membership.
- ~ The member understands the Club rules and policies, and understands that he/she is required to have a Club card to check-in.
- ~ My child and I understand Club membership is a privilege and may be canceled at any time for any reason.
- ~ I understand that membership is reserved for youth enrolled in Kindergarten through 12th Grade. Members must be enrolled in school and be below the age of 18, verification of school enrolment and grade is required.
- ~ I agree to pay \$5.00 per year for my child's membership.  
If my child's membership card is misplaced or destroyed, I agree to pay \$1.00 to replace the card.
- ~ I understand the Club is not responsible for any of my child's lost or stolen items. I will encourage my child to leave valuables at home.
- ~ I am aware of the Club's operating hours, and understand that I am solely responsible for my child's care outside these posted hours. Leaving my child alone before the Club opens, or picking up my child after the Club closes can result in loss of membership and notification of the authorities
- ~ I grant the Club the right to photograph and record my child and to use these as promotional materials. I release all right to copyrights title, property interest and/or any other interest of said reproductions, and I waive the right to inspect and approve any reproductions.
- ~ I understand that my child may be given surveys. These will be kept private, and are used to improve the Club and fulfill grant requirements.
- ~ I understand that my child will have access to the Internet at the Club.

*This organization participates in the Sprockets network and other program improvement research initiatives which aim to improve the quality and availability of after-school and summer programs for youth and their families in the Twin Cities. Information about your child's participation in this activity will be used to help assess the quality and effectiveness of out of school time programs. Information about your child will be kept confidential and your child will never be identified in any evaluation or research reports. You have the right to review the Data Privacy Notice. If you do not want your child's data to be included in evaluation or research related to Sprockets, please tell our staff and sign the non-consent form. This will NOT affect your child's participation in the program.*

Parent or Guardian Signature \_\_\_\_\_ Member's Signature \_\_\_\_\_ Date \_\_\_\_\_