MAKING STRIDES

A Division of PACES, LLC

After School Program Application

Child's Name: _____

First, Middle, Last

Preferred Name: _____

Date of Birth: _____ / _____ / _____ Sex: ___ Male ___ Female

Primary Language: ___ English ___ Spanish ___ Other: _____

Primary Address: _____

Street Address

_____, ____ _____

City *State* *Zip Code*

_____

County of Residence

Child Lives With: ___ Both Parents ___ Mother only ___ Father only

___ Other: _____

Legal Custody: ___ Both Parents ___ Joint Custody ___ Other: _____

___ Mother Only ___ Father Only

Parent/Guardian 1: _____

Relationship: ___ Mother ___ Father ___ Other: _____

Primary Address: _____

Street Address, if different from child

_____, ____ _____

City *State* *Zip Code*

Phone Numbers: _____ _____

Primary *Secondary*

Email Address: _____

Employer: _____

Occupation: _____

Work Phone: _____ Ext: _____

Parent/Guardian 2: _____

Relationship: ___ Mother ___ Father ___ Other: _____

Primary Address: _____

Street Address, if different from child

_____, _____ _____

City *State* *Zip Code*

Phone Numbers: _____ _____

Primary *Secondary*

Email Address: _____

Employer: _____

Occupation: _____

Work Phone: _____ Ext: _____

Emergency Contact: _____

Relationship: _____

Primary Address: _____

Street Address, if different from child

_____, _____ _____

City *State* *Zip Code*

Phone Numbers: _____ _____

Primary *Secondary*

Email Address: _____

Child's Physician: _____

Physician Phone: _____

Physician Address: _____

Street Address

_____, _____ _____

City *State* *Zip Code*

Preferred Hospital: _____

Name of Hospital

_____

Street Address

_____, _____ _____

City *State* *Zip Code*

Child's Diagnosis: Please list any diagnoses or medical conditions below (if any).

Current Academic Status

Please rate your child in the following developmental areas:

	Within Normal Limits	*Mildly Delayed*	*Moderately Delayed*	*Significantly Delayed*
English/Language Arts				
Mathematics				
Science				
Social Studies/History				
Study Skills				
Social/Pragmatic Skills				
Handwriting Skills				

Does your child currently have a 504 Plan or IEP? ____ No _____ Yes (please attach)

Current Medications: *Please list name, dosage, and frequency of any current medications.*

_____

_____

_____

Child's Allergies: *Please list any allergies along with possible reactions.*

_____

_____

_____

Health Insurance

Primary Insurance

Insurance Provider: _____ Policy #: _____

Policy Holder: _____ DOB: _____

Secondary Insurance

Insurance Provider: _____ Policy #: _____

Policy Holder: _____ DOB: _____

I, as the custodial parent/guardian of the child applicant for Footsteps Learning Center, acknowledge that the application fee is a one-time non-refundable fee, and paying this fee in no way guarantees my child will be chosen for Footsteps Learning Center.

_____ _____

Parent/Guardian Signature *Date*

_____

Parent/Guardian Printed Name

_____ _____

Witness Signature *Date*