



CELEBRATE PRIMARY

2026-2027 APPLICATION FORM



An After School Discovery program for 1st and 2nd grade students at Lakeside Elementary Campus
Fill out completely and return to ASD, PO Box 113, Ashtabula, OH 44005-0113 Business Office 440-993-1060

Child Name (Print) _____ Birthdate ____/____/____
Last First
School Child Is Attending _____ Teacher _____ Grade _____ ☐ M ☐ F
Parents/Guardian (print) _____ My relationship to this student _____
Home Address _____ T-shirt size _____
City _____ State _____ Zip _____ Email Address _____
Cell _____ Other Cell _____ Work/Other _____

Ethnicity ☐ Asian ☐ Black/African American ☐ Hispanic ☐ White ☐ Mixed (check all)
☐ My child has an IEP (Individualized Education Plan) ☐ My child is in ESL (English as a Second Language)

7:00 - 8:00 AM My child will attend the following days **before school at Ontario Primary School**. I will provide their transportation.
☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

3:00 - 5:30 PM My child will attend the following days **after school at Ontario Primary School**
☐ Tuesday ☐ Wednesday **MUST SELECT both AFTERNOONS**

TRANSPORTATION HOME:

☐ I give my permission for my child to be transported home at 5:30 pm from **Ontario Primary School** by an approved transportation service. I am aware there is limited transportation available. I am aware that my child must behave appropriately to be eligible to use the transportation.

OR PARENT PICK UP:

☐ My child may be signed in/out and released to any of the following adults besides myself at 5:30 pm. **Drop Off/Pick Up location is at the cafeteria at ONTARIO Primary**. Park in the Parent Loop in front of cafeteria. Ring the bell at the cafeteria outside door.

Adult name _____ relationship _____ phone _____

Adult name _____ relationship _____ phone _____

Adult name _____ relationship _____ phone _____

A. After School Discovery, Inc. (ASD) occasionally uses students' photographs, pictures, or works created for promotion or other uses, including media releases and web site postings. I grant to ASD as the sole owner, the right to photograph film and otherwise use my child's likeness and created works without any compensation whatsoever and understand that pictures may appear on social media.

B. After School Discovery, Inc. (ASD) works closely with the Ashtabula Area City Schools and is requesting your consent for records to be released between your school and ASD to aid in present and future educational plans.

C. I give permission for my child to participate in walking routine trips to common areas on the Wade Avenue campus including restrooms, between buildings, to the playgrounds, gym, etc. Upon dismissal from AM Celebrate or school, my child will be transitioned to their school or PM Celebrate Primary by ASD staff. No water activities are planned in water that is 18" or more in depth.

D. I understand a copy of ASD's Parent Handbook is available on request.

I hereby warrant that I am the parent and/or legal guardian of the above-named child and that I have the authority and authorization to sign this application form on behalf of said minor child. By signing below, I also agree to the statements above. If I am not in agreement with any of the above statements, I will inform After School Discovery in writing of my intentions.

Parent/Guardian Signature **X** _____

Parent/Guardian (Print) _____ Date _____

Mail Application back to AFTER SCHOOL DISCOVERY, PO Box 113, Ashtabula, OH 44005-0113 or have student take completed form to their school office.

Please complete ALL sides

CHILD ENROLLMENT FORM FOR EARLY CARE AND EDUCATION PROGRAMS

Parents: Complete this form or an electronic version in its entirety prior to the child's first day of attendance, review annually, and update as needed. The program may supplement or substitute this document with their own content equivalent form and request additional information from the parent/guardian.

Child's Name		Date of Birth		First Day at Program	
Address					
City		State		Zip Code	
Parent #1 Name		Parent #1 Phone Number			
Parent #1 Address ☐ Same as Child's		City		State	Zip Code
Parent #1 Email Address (if applicable)		Parent #1 Cell Phone (if applicable)			
Parent #1 Work/School Name (if applicable)		Parent #1 Work/School Phone Number (if applicable)			
Check here if Not Applicable ☐	Parent #2 Name		Parent #2 Phone Number		
Parent #2 Address ☐ Same as Child's		City		State	Zip Code
Parent #2 Email Address (if applicable)		Parent #2 Cell Phone (if applicable)			
Parent #2 Work/School Name (if applicable)		Parent #2 Work/School Phone Number (if applicable)			
Primary Emergency Contact #1 Name (cannot be parent/guardian)		Check here if Not Applicable ☐	Optional Emergency Contact #2 Name (cannot be parent/guardian)		
Primary Emergency Contact #1 Phone Number		Optional Emergency Contact #2 Phone Number			
Primary Emergency Contact #1 Other number or email address for emergency contact (if applicable)		Optional Emergency Contact #2 Other number or email address for emergency contact (if applicable)			
My child may be released to this emergency contact ☐ Yes ☐ No		Optional My child may be released to this emergency contact ☐ Yes ☐ No			
Does your child have a chronic health condition or diagnosis that requires the program to: observe or monitor symptoms, administer medication, serve medical foods, perform medical procedures, avoid specific foods/environmental conditions/activities, or allow a school age child to carry and administer their own medication? ☐ Yes (complete or provide a Health Care Plan, documentation from a licensed physician, or an electronic equivalent) ☐ No					

Child's Name		Date of Birth	
Information on my child's development: (personal, behavior, patterns, habits, and individual needs, etc.)			
☐ N/A			
The following accommodation(s) may be helpful to most effectively meet my child's needs while at the program:			
☐ N/A			
My child will receive specialized/individual services at the program:			
☐ Yes ☐ No			
Name of service provider(s) and frequency			
☐ N/A			
Emergency Transportation Authorization			
☐ The program has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.			
☐ The program does not have permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:			
SIGNATURE			
This form should be reviewed 12 months from the date the parent acknowledges accuracy and receipt of policies and procedures.			
Parent Acknowledgement of Accuracy and Receipt of Policies and Procedures			
By signing this form, I attest that the information is accurate and that I have reviewed and received a copy of the program's policies and procedures (parent handbook).			
Parent Signature		Date	
X			
Program Acknowledgement of Completion			
By signing this form, I attest that I have reviewed for completeness and that this form has been signed by the parent/guardian. This form is to be completed prior to the child receiving care.			
Program Administrator/Designee Signature		Date	
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

FAMILY INFORMATION

Child's Name

Nickname (if any)

By providing complete information about your child, you will be assisting the staff in creating a positive experience for him/her while in our care. List any information about your child's habits, abilities, or personality that you feel will be helpful to the staff who care for your child.

Members of child's immediate family

Who lives at home with your child?

Are there any special family arrangements, such as shared parenting or custody specifications etc.? ☐ Yes ☐ No

What languages are spoken in your home?

Primary Language?

Changes or transitions that your child recently experienced or is experience? (i.e. new home, birth of sibling, divorce, school issues, death of family member, friend, pet)

Any cultural or religious practices of your family of which we should be aware? (dietary restrictions, head coverings, clothing, language, etc.)

What are your child's favorite foods?

What are the foods your child dislikes?

Are there any foods your child should not be fed? (Child Care Licensing requires a form to be completed for children with food allergies or dietary restrictions)

What time does your child normally wake up and go to bed at night on a school night?

Wake Up _____ Go to Bed _____

What is your child's favorite subject (s) in school?

What subject (s) is a challenge?

What causes your child to feel angry or frustrated?

What methods do you use to respond to your child's negative behavior?

How do you reward your child's good behavior or accomplishments?

What are some of your child's interests?
Is your child taking any lessons or participating in organized clubs/teams? (i.e. swim, dance, piano, scouts, soccer, youth groups, etc.)
Average number of hours per day your child watches TV/DVD's during the school week? Less than 1 hour 1 – 3 hours 4 or more hours per day
Average number of hours per day your child has access to the items listed below: Computer/I-pad Cell phone Video Games
Please circle all of the words that best describe your child's personality and general behavior: active adventurous affectionate anxious bossy calm cautious cheerful content creative curious emotional energetic excitable friendly happy insecure likes structure/routine loud loving outgoing quiet prefers adult attention sensitive serious stubborn talkative
What makes your child laugh?
Please rank from 1 – 10 (10 being the most important) the importance of before and after school activities: Snack Art & Drama Physical Activity Structured Play Friends Rest Homework Safe Environment Learning Activities Free Play
Has your child had a previous care arrangement? ☐ Yes ☐ No If yes, what type (center based, in-home, with family, summer camp, youth program)
What are your expectations of this program?
Any other information that would be helpful for the staff caring for your child to know?
Does your child have an IEP (Individualized Care Plan) or an IFSP (Individualized Family Service Plan)? ☐ Yes ☐ No If yes, would you be willing to provide the program a copy so our staff can support your child and family. ☐ Yes ☐ No
Do you or anyone in your family have a hobby, skill, or area of expertise you would be interested in sharing with school age youth? ☐ Yes ☐ No Please tell us more:
X _____ Parent/Guardian Signature _____ Date

Please complete all sides

Ohio Department of Children and Youth

FAMILY NEEDS SURVEY FOR STEP UP TO QUALITY (SUTQ)

<i>We want to support any needs you or your family may have. THE INFORMATION YOU PROVIDE ON THIS FORM IS CONFIDENTIAL</i> Please circle Y (YES) or N (NO) to best describe your current situation for each topic. If you circle Y for an item, please briefly list the CONCERN if this is an area of need for your child or family. Our goal is to provide resources to support you and your family, based on your answers.		
Child's/Children's Name(s):	Caretaker's Name:	
Date Completed:		
TOPICS		
Child Development and Education- Does anyone in your family have any need for resources or support in the areas listed below?		
Y	N	Information on child growth and development.
Y	N	Guiding and supporting a child's behavior.
Y	N	Medical or disabilities or possible conditions for any child or adult in the family.
Y	N	Obtaining toys or activities to use to help any child in your home.
Y	N	Preparing your child for kindergarten.
Child and Family Health- Does anyone in your family have any need for resources or support in the areas listed below?		
Y	N	Health insurance and/or access to regular medical care, dental care, or medications.
Y	N	Medical or health supplies or supports that anyone in your family needs.
Y	N	Accessing immunizations.
Y	N	Finding a pediatrician, general practitioner, dentist, therapist, psychologist, optometrist, or other specialty practitioner.
Y	N	Concerns with depression, anger, anxiety, or mental health needs.
Y	N	Concerns with alcohol, drug, or addiction problems.
Financial and Household Supports- Does anyone in your family have any need for resources or support in the areas listed below?		
Y	N	Help paying for child care.
Y	N	Help finding housing or safe housing.
Y	N	Help paying your mortgage or rent.
Y	N	Help with food expenses.
Y	N	Finding household items such as furniture, clothing, or school supplies.
Y	N	Access to transportation or transportation expenses.
Y	N	Attending school (such as a GED, Certifications, or college degrees)
Y	N	Help finding work or job training

Are there other needs you or your family have that are not listed above:		
Parent Signature		Date:
*		
Administrator or Designee Signature:		Date:
For Staff Use:		
Bronze Rating Level	Silver Rating Level	Gold Rating Level
Resources provided to the family:	Resources provided to the family:	Resources provided to the family:
Administrator or Designee Signature & Date:	Administrator or Designee Signature & Date:	Administrator or Designee Signature & Date:
	Referrals provided to the family:	Referrals provided to the family:
	Administrator or Designee Signature & Date:	Administrator or Designee Signature & Date:
		Follow-up provided to the family:
		Administrator or Designee Signature & Date: