DISCOVERY COVE

2026-27 APPLICATION FORM

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

asd after school DISCOVERY

Child Name (Print) _____ _____ Birthdate ___/___/___
Last First

School Child Is Attending _____ Teacher _____ Grade _____ ❑ M ❑ F

Parents/Guardian (print) _____ _____
My relationship with this student

Home Address _____

City _____ State ____ Zip _____Email Address _____

Cell _____ Other Cell _____ Work/Other _____

Ethnicity ❑ Asian ❑ Black/African American ❑ Hispanic ❑ White ❑ Mixed

❑ My child qualifies for financial assistance through Ohio Department of Job and Family Services

❑ My child has an IEP (Individualized Education Plan)

DISCOVERY COVE – a **FEE** based before and after school youth development center held at ONTARIO Primary: **Please indicate the days** and **approximate time** you will be dropping off and/or picking up your child at Discovery Cove. **Schedules can be flexible with prior notification to Discovery Cove staff. Times of operation begin at 6:00 am and end at 6:00 pm.**

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
AM	AM	AM	AM	AM
PM	PM	PM	PM	PM

My child may be signed in/out and released to any of the following adults beside myself. **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. Anyone not listed needs to show a valid picture ID after we have received your permission to add them.

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 Discovery Cove/school, my child will be transitioned to/from Discovery Cove 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 with 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_____

☐ **I have enclosed the non-refundable $25 Application Fee ($40 Family fee)** ☐ Cash ☐ Check

Make check payable to **AFTER SCHOOL DISCOVERY** **Please complete all pages**

Ohio Department of Children and Youth

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	Optional My child may be released to this emergency contact
☐ Yes ☐ No	☐ 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

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)

We want to support any needs you or your family may have. THE INFORMATION YOU PROVIDE ON THIS FORM IS CONFIDENTIAL

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	Briefly List CONCERN
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: