## ŜΜILE

## THE SMILE PROGRAM MEMBERSHIP APPLICATION 2019-2020

DISTRICT	SCHOOL		
STUDENT STATE ID#		······································	
	FIRST NAME	М.І.	
Date of Birth/ / 0	ender Identity: lale Female Non-binary ther (indicate): ecline to Answer	Grade in School in 2019/2020	
Preferred Pronouns: He/Him She/Her	They/Them Ze/Zer		
Current address:			
City:	State:	ZIP Code:	
Have you ever been in SMILE before? YES NO If YES, what grades?			
STUDENT ETHNICITY (CHECK ALL THAT APPLY)         Black White Native American Asian         Hispanic/LatinxOther (specify) Choose not to identify			
PARENT 1/GUARDIAN INFORMATION			
Name:			
Mailing Address:			
City:	State:	ZIP Code:	
Best Contact Number:	Cell/Work Number:		
PARENT 2 (IF APPLICABLE)/GUARDIAN INFORMATION			
Name:			
Mailing Address:			
City:	State:	ZIP Code:	
Best Contact Number	Cell/Work Number:		
Have any of the adults living in your household been to college? YES NO			
Is your child <u>eligible</u> for free/reduced lunch?	YES N	0	
Permission to Participate in SMILE Program           (must be signed by parent or guardian before a student can join the SMILE Program)           1. I give permission for to be a member of SMILE			
<i>Name of Student (please print)</i> and for SMILE teachers to check my child's report card <u>and f</u> or SMILE staff to track their progress in school.			
2. Pictures are often taken during SMILE activities. I give permission for pictures of my child to be used by the SMILE Program			
for publicity purposes, including but not limited to, our webpage and social media. YES NO			
<ol> <li>Adults who are involved in a child's education contribute to their success. At least one family member must attend the district-wide Family Science Night on</li> </ol>			
Parent Signature		Date:	
Student Signature		Date:	

I want to be in SMILE because:				
Careers/jobs that interest me:				
HEALTH AND MEDICAL RECORD FOR CLUB, ANNUAL ACTIVITIES AND FIELD TRIPS				
Name of Child	School District	Grade		
Please check all that apply to your child. If you check any conditions, please explain.				
Asthma Diabetes Heart Trouble Bed Wetting Other:		sions leeding		
If my child becomes ill or injured when away from home during SMILE activities, you have my permission to seek medical treatment for him/her. I understand that I will be contacted immediately if medical treatment is necessary. List any known health concerns, such as allergies, that we need to know about. <b>Please fill in all blanks. If the statement does not apply to your child, write "none".</b>				
Allergy or reaction to any medication, food, ect Please list				
Allergy to bee sting; describe reaction				
List any dietary restrictions for medical or religious reasons				
Instructions for any medication child may bring the				
Describe any restrictions of activity for medical reasons				
Describe any mental or emotional problems Date of last tetanus inoculation (must be current)				
NOTE TO PARENTS:				
If your child has a special medical condition, a medical clearance from your family doctor is necessary. If no clearance is received, we reserve the right to not accept your child to the activity. Medication taken during the activities should be checked in with adult supervisor BEFORE the activity. If you feel, there are any circumstances you would like to discuss with SMILE staff, please call or write to The SMILE Program office 401-874-2036 or cenglander@uri.edu. We would be glad to discuss it with you. Please feel free to discuss these matters with your child's SMILE teachers also.				
In case of emergency, this will authorize physician and/or hospital to provide medical treatment:				
dentification/Group #		ild		
EMERGENCY CONTACT				
If you cannot be reached in case of emergency, please list a contact number for a trusted adult.				
NAME: RELATIONSHIP TO CHILD: PHONE NUMBER:				
SIGNATURES				
Parent (Guardian)Signature:		Date:		