Please indicate your Race:

INTAKE APPLICATION

"We are the change, Offering Our Youth, a Greater Life"

PERSONAL INFORMATION

NEW STUDENTS

REFERRED BY: ______________________________________ **CONTACT #:** ________________________________

	HOUSEHOLD SIZE							
Income Category	1	2	3	4	5	6	7	8
Low (80%)	$32,550	$37,200	$41,850	$46,500	$50,250	$53,950	$57,700	$61,400
Very Low (50%)	$20, 350	$23,250	$26,150	$29,050	$31,400	$33,700	$36,050	$38,350
Extremely Low	$12,760	$17,240	$21,720	$26,200	$30,680	$33,700	$36,050	$38,350

Household Income: $______________ Family Size:_________ **3 Months Paystub Required**

Child's Full Name: ______________________________ Parent/Legal Guardian: ___________________________
Print (LG) Print

Child's Date of Birth: _______ Age: ___ Elem/Middle: ______________ Grade: ____ School:_______________

Parent/LG: Cell: ____ _____ Ok leave a message ______ Not Ok

Parent Work #: _______________________________ Parent/LG EM: __________________________________

Mailing Address: ____

REFERRAL REASON

What classes does your child struggle in? ____,

____.

Is the child receiving special education services (IEP), if so, what services?
____.

Is your child involved in any extra-curricular activities now, such as music, student body council, sports, etc.?
__ Yes __ No. If yes, list them: ____.

What are your child's goals after graduating high school?
____.

What things does your child like doing or enjoy doing? ____.

What are some of their hobbies, if any? ____.

Do you desire a Mentor, if so why? ☐ YES ☐ NO

HEALTH INFORMATION

Health Information _____/_____ Initials (parent/LG/child) Medicaid: ____________________

Does your child struggle with allergies? Please explain: ____.

Medical concerns (Y) (N). If yes, please list and prescribed medications. ____________________________.

How often? ____.

Name of Primary Care Physician: _____________________________ Physician Ph.#: _________________

Address: ____ Medical Insurance: ______________
(provide copy of medical card)

Name of Specialist Physician: _______________________________ Specialist Ph#: __________________

Address: ____.

Emergency contact: ________________________________ Work Ph.#: _________ Cell ______________

PLEASE NOTE: All medications must be taken before coming to the program. Greater Life is not responsible or qualified to administer medication to students.

ALTERNATIVE TRANSPORTATION PROVIDER:

Name: ____ Contact Number: ________________________

Relationship: ____.

Valid Driver's License Number/State): ____

____ _______________________________________
Parent/Legal Guardian Signature Student/Child Signature

DATE: ____________________ DATE: __________________