



**San Juan Unified School District  
Bridges After-School Program  
Application for Enrollment 2026-27**



<b>School Attending</b>	School:				
<b>Child's Name</b>	Last:		First:		
<b>Child's Address</b>	Street Address		City	State	Zip
<b>Date of Birth</b>		<b>Gender</b>	Male	Female	Non-Binary
<b>Grade/Teacher</b>					
<b>Bilingual</b>	Yes	No	Languages Spoken:		
Parent/Guardian:				Relationship:	
Phone:				Email:	
Parent/Guardian:				Relationship:	
Phone:				Email:	
Sibling of a Current Bridges Student?	Yes	No	Sibling Name & School:		

**PRIORITY ENROLLMENT:** Priority will be given to students who qualify under the McKinney-Vento Homeless Assistance Act, Foster Youth, English Learners, and students eligible for free or reduced-price meals. If your student qualifies for any of the priority groups, please check here:

**PARTICIPATION:** Bridges After-School is open to all students who would like to participate and is offered on a first-come, first served basis after priority is applied. Program participation requires adherence to all policies and guidelines as described below. Parents/Guardians are required to attend a parent orientation at the beginning of the school year.

**ATTENDANCE:** The program operates from the end of the school day until at least 6:00 PM. If a student is absent, parents are required to notify the Bridges program staff, in addition to the traditional school day staff. An accumulation of 10 unexcused absences may be considered excessive. Students may be picked up before the end of program time in accordance with the Bridges After-School Early Release Policy.

**STUDENT PICK-UP:** Students must be picked up promptly at the end of Bridges After-School daily. If a student has not been picked up by the end of the program, Bridges staff will contact the parent/guardian and individuals designated as emergency contacts. Bridges After-School may dismiss a student from the program after 3 late pick-ups.

**STUDENT BEHAVIOR:** All students must follow San Juan Unified School District's school rules and any additional policies of the Bridges After-School Program. **Disruptive behavior, disrespectful behavior toward other students or staff or behavior that creates a safety concern is a reason for dismissal.** Bridges After-School staff will notify and/or involve parents/guardians in behavior interventions that occur. It is encouraged that parents/guardians discuss concerns about any behavior with the Bridges After-School Site Facilitator .

**\*THE BRIDGES AFTER-SCHOOL PROGRAM WILL NOT TOLERATE VIOLENCE, DRUGS, RACIAL SLURS, SEXUAL HARASSMENT, INAPPROPRIATE TOUCHING OR PERSONAL PUT-DOWNS TOWARD OTHERS. IF ANY OF THESE INCIDENTS OCCUR, DISCIPLINARY ACTION WILL BE TAKEN IMMEDIATELY AND COULD RESULT IN TERMINATION FROM THE PROGRAM.**

I have read and understand all of the information above. With my signature on this document, I agree to adhere to all of the Bridges After-School Policies and Guidelines and help my student understand and follow Bridges After-School guidelines.

Funding for the Bridges After-School program requires that statistical information for participating students is collected and reported. Evaluators keep the information confidential and no information is reported on individual children. Parent names, student names and all identifying information will be kept anonymous and will not appear in any printed report from the study.

With my signature on the Bridges After-School Application for Enrollment, I acknowledge receipt of this document and agree and give my consent to the confidential collection and reporting of statistical information.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**BRIDGES STAFF USE ONLY**

Returning Bridges student Y \_\_\_ N \_\_\_ If yes, from what school? \_\_\_\_\_ Student ID Number \_\_\_\_\_

Date application was received \_\_\_/\_\_\_/\_\_\_ Time application was received \_\_\_\_\_ Student's start date \_\_\_/\_\_\_/\_\_\_

HS/FY Verified Y \_\_\_\_\_ N \_\_\_\_\_ Initials \_\_\_\_\_



San Juan Unified School District  
Bridges After-School Program  
Emergency Information 2026-27



Child's Full Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

Address \_\_\_\_\_ Child resides with: \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Relationship \_\_\_\_\_

Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Relationship \_\_\_\_\_

Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

**Emergency Information:** Students will only be released from the program with a parent/guardian signature or that of an individual designated below. If your child is ill or has an emergency and a parent/guardian cannot be reached, your child may be released to a designated emergency contact. Emergency contacts must be 16 years or older. *Parents/Guardians are required to update emergency information as changes occur.*

**EMERGENCY CONTACTS: (minimum of two required)**

NAME	RELATIONSHIP	HOME PHONE	CELL PHONE

**Parent/Guardian Must Check One**

1. In the event of an emergency, when a parent or guardian is unavailable, I authorize school personnel to make arrangements for my child to receive medical/hospital care, including necessary transportation, in accordance with their best judgment. I authorized the physician named below to undertake such care and treatment as is considered necessary. In the event said physician is unavailable, I authorize such care and treatment to be performed by a licensed physician or surgeon. I agree to pay all costs incurred as a result of the foregoing.

2. I do not choose the above statement and desire the following action in the event of an emergency:

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Coverage: \_\_\_\_\_ ID#: \_\_\_\_\_

**VISION:**  wears glasses  wears contacts  to be worn at all times  requires preferential seating Date of last eye exam \_\_\_\_\_

**HEARING:**  has a hearing problem  has tubes in ears  uses hearing aid  requires preferential seating

**GENERAL HEALTH: 1.** Has the following condition(s):  asthma  epilepsy  fainting spells  diabetes  hyperactive (ADHD)  migraines

heart condition  allergies \_\_\_\_\_ allergic reaction to bee stings (describe): \_\_\_\_\_  Other \_\_\_\_\_

2. List Medications Prescribed: \_\_\_\_\_ Current Dosage: \_\_\_\_\_

For (diagnosis) \_\_\_\_\_ Prescribed by Dr. \_\_\_\_\_ Phone \_\_\_\_\_

3. Has a physical condition which limits participation  no  yes (explain): \_\_\_\_\_

4. Has Special Needs  no  yes (explain): \_\_\_\_\_

"I authorize the release of my child's medical information 1. by the school district and the provider of services to the billing agent and 2. by the school district to my insurance carrier as necessary to process a claim or to request payment of Medical Assistance Benefits. Shared information will be limited to health service documentation only."

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Relationship \_\_\_\_\_