



San Juan Unified School District
Expanded Learning Opportunities Program / YMCA
Application for Enrollment 2026-27



School Attending	Del Paso Manor			
Child's Name	Last:		First:	
Child's Address	Street Address		City	State Zip
Date of Birth		Gender	Male Female Non-Binary	
Grade/Teacher				
Program	Before-School (YMCA)		____ Current Bridges After-School Student at DPM	
Bilingual	Yes No	Languages Spoken		
Parent/Guardian:		Relationship:		
Phone:		Email:		
Parent/Guardian:		Relationship:		
Phone:		Email:		
Sibling of a Current YMCA or 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: The Expanded Learning Opportunities Program 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: If a student is absent, parents are required to notify the ELO-P staff, in addition to the traditional school day staff. An accumulation of 10 unexcused absences can be considered excessive. Students may be picked up before the end of program time in accordance with the ELO-P Early Release Policy.

STUDENT BEHAVIOR: All students must follow San Juan Unified School District's school rules and any additional policies of the ELO-P. **Disruptive behavior, disrespectful behavior toward other students or staff or behavior that creates a safety concern is a reason for dismissal.** ELO-P 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 ELO-P staff. ***THE EXPANDED LEARNING OPPORTUNITIES 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 ELO-P Policies and Guidelines and help my student understand and follow ELO-P guidelines.

Funding for ELO-P 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 ELO-P 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:** _____

STAFF USE ONLY

Returning ELO-P or 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
Expanded Learning Opportunities Program/YMCA
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 _____