



Please print NEATLY in blue or black pen

**The SMILE Program  
High School Membership Application 2011-2012**

School District \_\_\_\_\_ Student State ID Number \_\_\_\_\_  
 Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 E-mail: \_\_\_\_\_

Date of Birth ___/___/___	Gender: M / F	Grade in School this year: _____
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Have you been in SMILE before? YES \_\_\_ NO \_\_\_ IF YES, What grade(s)? \_\_\_\_\_

I want to be in SMILE because: \_\_\_\_\_  
 \_\_\_\_\_

Science Course(s) I am taking this year: \_\_\_\_\_, \_\_\_\_\_  
(Fall Semester) (Spring Semester)

Math Course(s) I am taking this year: \_\_\_\_\_, \_\_\_\_\_  
(Fall Semester) (Spring Semester)

Science career areas that interest me (highlight or circle):

Pharmacy	Mathematics	Engineering	Agriculture	Veterinary Medicine
Medicine	Computer Science	Food Science	Forestry	Fisheries & Wildlife
Biology	Physics	Chemistry	Geology	Other _____

<p><b>Mother/Guardian</b></p> <p>Name _____</p> <p>Cell/Work Number _____</p> <p>Home Number _____</p> <p>E-mail _____</p> <p>Mailing Address</p> <p>Street _____</p> <p>City _____ State _____ Zip Code _____</p>	<p><b>Father/Guardian</b></p> <p>Name _____</p> <p>Cell/Work Number _____</p> <p>Home Number _____</p> <p>E-mail _____</p> <p>Mailing Address</p> <p>Street _____</p> <p>City _____ State _____ Zip Code _____</p>
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**Student Ethnicity (check all that apply)**

African American ___	Hispanic ___
Asian American ___	Native American ___
Azores/Cape Verde ___	Caucasian ___

Other (specify) \_\_\_\_\_

Have any of the adults living in your household been to college? YES \_\_\_ NO \_\_\_

Is your child eligible for free/reduced lunch? YES \_\_\_ NO \_\_\_

Parent Signature _____	Date _____
Student Signature _____	Date _____

**HIGH SCHOOL**



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To be completed by Parent or Guardian
(Please read carefully & sign where applicable)

Permission to Participate in SMILE Program

(Must be signed by parent or guardian before a student can join the SMILE Program)

I give permission for \_\_\_\_\_ to be a member of SMILE and
Name of student (Please Print)

for SMILE teachers to check my child's report card and for SMILE staff to track their progress in school. 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. Yes\_\_ No\_\_

If possible, please attach a copy of student's most recent REPORT CARD to this form.

It is the expectation that at least one adult family member attend the district-wide Family Science Night on \_\_\_\_\_. Adults who are involved in a child's education contribute to their success.

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: \_\_\_\_\_

Health Insurance Company Identification/Group Number Insured person's name

Emergency Contact Person Phone Number

Signature of parent or guardian: Date:

By signing this form, you have read and understood all of the information on this page.

To be completed by SMILE Teacher(s)

Reason(s) for accepting student (please check all that apply):

Free/Reduced Lunch Female Minority Previously in SMILE ESL

Strong Science Interest Other Explain:

Based on your best knowledge, the student is working at grade level in all subjects: Yes No

Comments:

Signature of Teacher: Date:

HIGH SCHOOL



Please print NEATLY in blue or black pen

Health and Medical Record
For Club, Annual Activities, and Fieldtrips

Name of Child School District Grade

Please check all that apply to your child. If you checked any conditions, please explain.

- Asthma Diabetes
Fainting Heart Trouble
Convulsions Sleepwalking
Bedwetting Nose bleeding
Comments

Please fill in all the blanks. If the statement does not apply to your child, write "none".

Allergy or reaction to any medication, food, etc. Please list
Allergy to bee sting; describe reaction
List any food exclusions for medical or religious reasons
Describe any conditions now requiring regular medication
Instructions for any medication child may bring to the activity
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 not to 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 874-2036 or englanca@etal.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:

Insurance Company Policy #
Parent (Guardian) Name Relationship to child
Home Phone Emergency Phone

Parent (Guardian) Signature Date

If unable to contact parent or guardian, please call:

Name: Relationship to child: Phone: