Empowering Community Leaders Network, Inc.

2022-2023 Application

Sisters Wholesome Aspiring toward Greatness Mentoring Program (S.W.A.G.)

(To be completed by Parents)

Please return the completed application package (application, photo release, parent consent) to ECLN by Wednesday, May 25, 2022.

Date_____

First and Last Name_____

Prefers to be Called _____

Birthday_____ Ethnicity_____

Parent/Guardian_____

Address_____

City_____ State_____ Zip Code_____ Home Phone ( )_____

Email: Mother_____ Email: Father _____

Mobile Phone Mother ( )_____Mobile Phone Father ( )_____

Work Phone of either parent: circle one Mother/Father( )_____

Name and Emergency contact number ( )_____

Health concerns (allergies, medication, dietary restrictions) _____

_____

Any other pertinent information we should know about your daughter (special talents/abilities, learning needs, etc.)

_____

_____

ECLN may provide transportation for this program on a first come first serve basis. Please contact ECLN at **eclninc14@gmail.com**, if you are interested. Parents are responsible for their child's transportation home from the S.W.A.G. meetings which are held every Wednesday. Pick time is approximately 5:30 pm.

Please initial here _____, I give permission for my daughter to participate in ECLN's enriching, leadership development mentoring program.

Signature_____

Empowering Community Leaders Network, Inc.

S.W.A.G. Application

Sisters Wholesome Aspiring toward Greatness

This section to be completed by Student Applicant

Student's Name (First and Last)_____

Please provide ***an extended thoughtful response*** to the five questions below. Return with your application packet by May 25, 2022. A one sentence response is ***NOT*** acceptable. (*If additional space is needed, please attach another sheet of paper.)*

1. What is your understanding of S.W.A.G.?

2. ***Describe*** at least three qualities you bring to S.W.A.G.

3. S.W.A.G. is a Leadership Development Mentoring Program. How do you think participating in S.W.A.G. will help you in Middle School and beyond?

3. How would your family, friends or someone who knows you well, describe your character?

4. Describe one interesting fact about yourself.

Empowering Community Leaders Network, Inc.

S.W.A.G. 2022-2023

Parental Consent for _____ Middle School to Share Academic Information (optional)

I give the above-mentioned Middle School permission to share my daughter's academic and behavioral data with Empowering Community Leaders Network, Inc., and it's designated S.W.A.G. mentors. The data may include progress reports, report card grades, attendance, office referrals and communication with school staff, as appropriate.

I understand this information will be held ***confidential*** and used ***strictly*** for S.W.A.G. programming (celebrations of mentee's academic successes and accomplishments and assisting a mentee who might experience academic challenges).

Permission granted on _____
Date

Student Name _____

Parent Name_____

Parent Signature _____

Empowering Community Leaders Network, Inc.

S.W.A.G. 2022-2023

Photo Release Form

I hereby grant Empowering Community Leaders Network, Inc., nonprofit organization, the right to take photographs or videotapes of my child.

I agree that Empowering Community Leaders Network, Inc. may use such photographs of my child, for publicity, illustrations, public affairs releases, marketing, advertising and ECLN's website.

This authorization is continuous and may be withdrawn or revoked by providing written notification.

I acknowledge that I have read the foregoing and understand the contents:

Parent's Name _____

Signature of Parent/Guardian_____

Student's Name_____

Date_____

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Empowering Community Leaders Network, Inc.

Emergency Form

Instructions to Parents: Complete all items on this side of the form. Sign and date where indicated. If your daughter has a medical condition which might require emergency medical care, complete the back side of the form. NOTE: ***THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.***

Daughter's name _____ Birth Date ___/___/___
Last First MI

Home Address_____
Street City State Zip Code

Parent/Guardian Name _____ Work Phone _____ Cell Phone _____

Name of person (s) authorize to pick up daughter from SWAG

_____
Last First Relationship

Address_____
Street City State Zip Code

School Name _____ Grade_____ Age_____

Annual Updates _____ _____ _____ _____
(Initials/Date) **(Initials/Date)** **(Initials/Date)** **(Initials/Date)**

Emergency Contact

When parents/guardians cannot be reached, list at least one person who may be contacted in an emergency to pick up your daughter.

Name
_____
Last First (H) Phone (W) Phone

Name
_____
Last First (H) Phone (W) Phone

Daughter's physician or source of health care_____ Phone_____

Address_____
Street City State Zip code

In EMERGENCIES requiring immediate medical attention, your daughter will be taken to the nearest hospital emergency room. Your signature authorizes the responsible person at ECLN/SWAG to have your child transported to that hospital.

Signature of Parent/Guardian _____ **Date** ____/____/_____

Created October 2021

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Instructions for Parent/Guardian:

1. **Complete the following if your daughter has a condition(s) which might require emergency medical care.**
2. **If necessary, have your daughter's health care practitioner review the information you provide below and sign and date where indicated.**

Daughter's Name _____ Date of Birth _____/_____/_____

Medical Condition(s) _____

Medications currently being taken by your daughter. _____

Date of your daughter's last tetanus shot: _____

COVID Vaccination: ____ **YES** ____ **NO** If yes, Date of 1st Shot_____ Date of 2nd Shot _____ Booster _____

_

Allergies/Reactions _____

Emergency Medical Instructions:

1. Signs/symptoms to look for:

_____
_____
_____
_____

2. If symptoms appear, do this:

_____
_____
_____

3. Other special instructions that may be needed:

_____
_____
_____

Comments:

Note to Health Care Practitioner:

If you reviewed the above information, please complete the following:

Name of Health Care Practitioner _____ Date _____/_____/_____

Signature of Health Care Practitioner _____ Phone (____)_____