EMERGENCY CONTACTS

Child's Name _____
Last First Initial

Child's Birth Date _____
Day Month Year

Name of the Father _____
Last First Initial

Name of the Mother _____
Last First Initial

Address _____

Telephone – Home # _____ Work # _____

Signature of Parent _____

EMERGENCY CONTACT #1

Name _____

Address _____

Telephone – Home # _____ Work # _____

Relationship to Child _____

EMERGENCY CONTACT #2

Name _____

Address _____

Telephone – Home # _____ Work # _____

Relationship to Child _____

EMERGENCY CONTACT #3

Name _____

Address _____

Telephone – Home # _____ Work # _____

Relationship to Child _____

Department of Youth and Community Development
Out-of-School Time Programs
Participant Enrollment Form

OST PROGRAMS

Participant Information

1. Last Name

2. First Name

3. Middle

4. Social Security Number ___ - ___ - ____

5. Gender ☐ Male ☐ Female

6. Birth Date ___ (Month) ___ (Day) ____ (Year)
☐ Birth Certificate ☐ Passport ☐ Official Letter

7. Street Address (number and street)

8. Apt #

9. Zip Code

10. Borough Code ☐ 1. Bronx 2. Brooklyn 3. Manhattan 4. Queens 5. Staten Island

11. Home Phone Number (Area code) ___ - ___ - ____

12. Cell / Pager (Area code) ___ - ___ - ____

13. Email Address:

14. Ethnicity ☐ 1. American Indian 2. Asian (Non-Hispanic) 3. Black (Non-Hispanic) 4. Hispanic/Latino 5. Pacific Islander 6. White (Non – Hispanic) 7. Other

15. Emergency Contact Name — Last Name / First Name

16. Home Phone Number (Area code) ___ - ___ - ____

17. Relationship to applicant

18. Emergency Contact 2 Name — Last Name / First Name

19. Home Phone Number (Area code) ___ - ___ - ____

20. Relationship to applicant

21. School Attending: _____

School Type: ☐ Public School ☐ Private School

22. Grade:

23. Public School Student ID# (OSIS):

24. Class Room #

25. Primary Teacher:

26. Primary Language Spoken

27. English Proficient ☐ Yes ☐ No

28. Are you or any member of your household (0-64 years of age) covered by Medicaid, Child Health Plus, Family Health Plus or private medical insurance? Yes ☐ No ☐

29. If NO, do you want to be contacted with information about public health insurance programs? Yes ☐ No ☐

30. Are you or any member of your household receiving Public Assistance? Yes ☐ No ☐ If Yes, HRA Code #:

31. Has the participant been enrolled in any of the following programs? ☐ **1. ACS** **2. Beacon** **3. TASC**

32. Do you have other children registered in this program? Yes ☐ No ☐

If yes, please list additional children below:

33. Additional Child — Last Name / First Name

34. Additional Child — Last Name / First Name

Pick-Up Permissions

35. ☐ I give permission for my child to walk home alone at dismissal.

Child may be picked up by:

36. Last Name **37.** First Name **38.** Middle

39. Home Phone Number (Area code) - - **40.** Relationship to applicant

41. Last Name **42.** First Name **43.** Middle

44. Home Phone Number (Area code) - - **45.** Relationship to applicant

46. Last Name **47.** First Name **48.** Middle

49. Home Phone Number (Area code) - - **50.** Relationship to applicant

Child <u>may not</u> be picked up by:

51. Last Name **52.** First Name **53.** Middle

54. Relationship to applicant (Area code)

55. Last Name **56.** First Name **57.** Middle

58. Relationship to applicant (Area code)

Parent / Guardian Information

59. Last Name

60. First Name

61. Middle

62. Street Address (number and street)

63. Apt #

64. Zip Code

65. Borough Code 1. Bronx 2. Brooklyn 3. Manhattan 4. Queens 5. Staten Island

66. Birth Date: Month Day Year

67. Home Phone Number (Area code) - -

68. Work Phone (Area code) - -

69. Cell / Pager Number - -

70. Email Address:

71. Ethnicity 1. American Indian 2. Asian (Non-Hispanic) 3. Black (Non-Hispanic) 4. Hispanic/Latino 5. Pacific Islander 6. White (Non – Hispanic) 7. Other

72. Relationship to applicant

73. Primary Language Spoken

74. English Proficient Yes No

Additional Parent / Guardian Information

75. Last Name

76. First Name

77. Middle

78. Street Address (number and street)

79. Apt #

80. Zip Code

81. Borough Code 1. Bronx 2. Brooklyn 3. Manhattan 4. Queens 5. Staten Island

82. Birth Date: Month Day Year

83. Home Phone Number (Area code) - -

84. Work Phone (Area code) - -

85. Cell / Pager Number - -

86. Email Address:

87. Ethnicity 1. American Indian 2. Asian (Non-Hispanic) 3. Black (Non-Hispanic) 4. Hispanic/Latino 5. Pacific Islander 6. White (Non – Hispanic) 7. Other

88. Relationship to applicant

89. Primary Language Spoken

90. English Proficient Yes No

Health Information

91. Please check any box that applies to your child:

	YES	NO
Allergies to food (please specify):	☐	☐
Allergies to medicine (please specify) :	☐	☐
Allergies Other (please specify):	☐	☐
Asthma	☐	☐
Behavioral/Emotional issues	☐	☐

	YES	NO
Convulsions/Seizures	☐	☐
Corrective Device (glasses, hearing aid, etc.)	☐	☐
Diabetes	☐	☐
Individualized Education Plan	☐	☐
Physical Disabilities	☐	☐
Other (please specify):	☐	☐

Children who have special health care needs are those who have chronic physical, developmental, behavioral, or emotional conditions expected to last 12 months or more and who also require health and related services of a type beyond that are required by children generally. If you child does have special health care needs please discuss these with your child care provider.

Please explain: _____

_____

_____

92. Does your child have special health care needs that require treatment and/or medication? ☐ YES ☐NO

Please explain: _____

_____

93. Does your child take medication for any condition or illness? ☐ YES ☐NO

Please explain: _____

_____

94. Are there any activities your child cannot participate in? ☐ YES ☐NO (if yes, please specify)

Please explain: _____

_____

CERTIFICATION STATEMENT

I, the undersigned, certify that all information on this form is true and correct. I understand that my statements are subject to verification. I agree and accept that I will abide by all applicable rules and regulations of this program. I consent to the enrollment and participant of the child listed above in this program.

Applicant Signature Date

Parent/Guardian Signature Date

Intake Officer Signature Date

CACFP
Child and Adult Care Food Program
New York State Department of Health

INCOME ELIGIBILITY APPLICATION
for Child Day Care Centers

See INSTRUCTIONS on reverse.

DAY CARE CENTER NAME: _____

Print the name of the child(ren) enrolled in Day Care:

1. _____ 2. _____ 3. _____

DIRECTIONS:

Complete SECTION A if your household:

1. Receives Temporary Assistance to Needy Families (TANF)
2. Receives Food Stamps
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR)
4. Currently has a foster child enrolled in day care

Complete SECTION B if Section A does not apply:

Sign, date and indicate the Social Security number of the adult signing the certification and return the completed form to the day care center.

SECTION A

TANF Number _____

Food Stamp Case Number _____

FDPIR Number _____

Foster Child's Name _____

Foster Child's Personal Monthly Income $ _____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true and correct and that all income is reported. I understand this information is being given for the receipt of Federal funds, that officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

Signature: _____

Date: _____

FOR SPONSOR USE ONLY

Sponsor Agreement Number _____

Total Household Members _____

Total Income $_____

Free _____ Reduced _____ Paid _____

Signature of
Determining Official _____

Date Determined _____ / _____ / _____

SECTION B

List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received **last month** in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, welfare payments, child support and any other sources of income.

Name of Household Members	Monthly Gross Income
1. _____	$ _____
2. _____	$ _____
3. _____	$ _____
4. _____	$ _____
5. _____	$ _____
6. _____	$ _____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true and correct and that all income is reported. I understand this information is being given for the receipt of Federal funds, that officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

Signature: _____

Print Name: _____

SS# _____ Date: _____

Section 9

Unless you list the child's food stamp, FDPIR or TANF case number or are applying for a foster child, Section 9 of the National School Lunch Act requires that you include the social security number of the household member signing the application or indicate that the household member signing the application does not have a social security number. You do not have to list a social security number, but if a social security number is not listed or an indication is not made that the adult household member signing the application does not have a social security number, we cannot approve the application. The social security number may be used to identify the household member in verifying the correctness of the information stated on the application. This may include program reviews, audits and investigations and may include contacting employers to determine income, contacting a food stamp, FDPIR or TANF office to determine current certification for food stamps, FDPIR or TANF benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims or legal actions if incorrect information is reported.

Definition of Income

Income means income before deductions for income taxes, social security taxes, insurance premiums, charitable contributions, and bonds, etc. It includes the following: (1) monetary compensation for services, including wages, salary, commissions or fees; (2) net income from non-farm self-employment; (3) net income from farm self-employment; (4) social security payments; (5) dividends or interest on savings or bonds, income from estates or trusts or net rental income; (6) public assistance or welfare payments; (7) unemployment compensation; (8) government civilian employee or military retirement, or pensions or veteran's payments; (9) private pensions or annuities; (10) alimony or child support payments; (11) regular contributions from persons not living in the household; (12) net royalties; (13) military benefits received in cash, such as housing allowance; and (14) any other cash income.

Definition of Household

Household means *family* as defined in Section 226.2. *Family* means a group of related or non-related individuals who are not residents of an institution or boarding house, but who are living as one economic unit.

INSTRUCTIONS FOR COMPLETING DOH-3688

Instructions for Parents or Guardians:

Write in the name of the day care center in the space provided.

Print the name of each child in your household who attends this day care center.

Section A: If your household receives Temporary Assistance for Needy Families (TANF) or Food Stamps or participates in the Food Distribution Program on Indian Reservations (FDPIR), complete Section A only. Write down the TANF, FS or FDPIR number (do not use your ACD or DSS child care subsidy number) and sign and date the form and return it to the day care center.

Foster children: If your household includes a foster child who is in day care, complete Section A only. Write in the foster child's name and any income that the child receives from social services for his or her personal use. Write in *0* if the foster child does not receive any income. A separate application must be completed for each foster child. The foster parent or an official who represents the child must sign and date the form and then return it to the day care center.

Section B: Write in the names of all the people living in your household, even if they do not have any income. Include yourself and all other adults and children in the household, including unrelated people. Do not include the children in day care, who are listed at the top of the form.

Enter the amount of income each person received **last month**, before taxes or anything else was taken out. Refer to the Definition of Income and the Definition of Household above. If any amount last month was more or less than the usual, write in that person's usual income. The signature and social security number of the adult signing the certification is required. If you do not have a social security number, write *none*.

Instructions for Centers and Sponsors

The *For Sponsor Use Only* section is to be completed, signed and dated by day care center or sponsor staff.

The sponsor/center representative must review the income eligibility application and ensure that it is completed as indicated in the instructions above. Then indicate the following:

The sponsor agreement number.

Total household members – This item does not have to be completed if the parent completed Section A. Add those indicated in Section B (if completed) to the children enrolled in day care.

Total Income – This item does not need to be completed if the parent completed Section A. Indicate the total monthly income as calculated from Section B. If the parent chooses not to disclose income, the application must be categorized as *paid*.

Free, Reduced or Paid – Compare the total household income and the total number of household members with the current year's Income Eligibility Guidelines (CACFP-3687) to determine if the household should be categorized as **Free, Reduced** or **Paid**. Use the appropriate column on the CACFP-3687 to categorize their income. For example, if the parent indicated biweekly income, multiply this amount by 26 to determine yearly income.

Incomplete applications (missing signatures, income information, social security numbers, TANF FDPIR or Food Stamp numbers) are categorized in the paid category.

The income eligibility application is valid for one calendar year only.

UNION SETTLEMENT ASSOCIATION, INC.
Youth @ Union
1775 Third Avenue, New York, NY 10029

CONSENT FOR CHILD'S EMERGENCY MEDICAL/DENTAL TREATMENT

Student's Name: _____ **Date of Birth:** _____

1. **If my child requires emergency medical care and I cannot be reached, I give my consent to the above after-school program to obtain the necessary medical care for my child. I agree to pay all of the costs associated with the emergency medical care that my child receives. I understand that every effort will be made to contact me before and after medical care is provided.**

1. **Following emergency medical care, my child may be released to the following people:**

Name:	_____	Relationship to Child:	_____
Address:	_____	Employer:	_____
Home Phone:	_____	Work Phone:	_____
Name:	_____	Relationship to Child:	_____
Address:	_____	Employer:	_____
Home Phone:	_____	Work Phone:	_____
Name:	_____	Relationship to Child:	_____
Address:	_____	Employer:	_____
Home Phone:	_____	Work Phone:	_____

1. **Health/Insurance Information:**

Student's Doctor:	_____	Insurance Company:	_____
Phone:	_____	Policy Holder's ID:	_____
Allergies:	_____	Religious Preference: (optional)	_____
Last Tetanus:	_____	Medication(s) being taken:	_____
Address (student's doctor):	_____		

Additional Comments: _____

_____

1. **I understand that this consent will be in effect as of the date of my signing this form and will continue as long as my child is enrolled in this after-school program.**

_____

Parent/Guardian Signature Date

UNION SETTLEMENT ASSOCIATION
RISING STARS
1775 Third Avenue, New York, NY 10029

Parent Consent to Participate in the Evaluation of the Out of School Time After-School Program

Dear Parent,

Your child, _____, is enrolled in the after school program at Washington Houses Community Center located at 1775 Third Avenue, New York, NY 10029, which is supported by the Department of Youth and Community Development (DYCD). In order to monitor the effectiveness of the after school program and ensure its future success, DYCD is conducting an ongoing evaluation. It is the intention of the evaluation to learn how these services help students and how they can be improved in order to meet the grant requirements.

Specifically we ask permission from parents to:

- Contact their children's school and obtain records showing their progress, including information about enrollment, grades, citywide and statewide test scores, and attendance.
- Talk to teachers and after-school staff about children's progress and participation in the after-school program, and review program records on participation in the after-school program.
- Survey and/or interview parents and children about the after-school program and its effects.

Any information we collect will be used only to assess the after-school program and will not be made public. Participating in the evaluation will not affect your child in school, in the after-school program, or in any other way. We will not use your name or your child's name in any report. At the end of the evaluation, we will destroy all records that include personal information. Participation in the study is completely voluntary and participants may withdraw at any time with no consequences.

Please select one of the options below and return this form to the program coordinator/director.

☐ *YES, I GIVE PERMISSION FOR MY CHILD TO PARTICIPATE. I have read the above information and I give permission for my child to participate in the evaluation of the after-school program. I also consent for DYCD to obtain my child's records and to interview program and school staff for evaluation purposes.*

_____
Signature Date

☐ *NO, I DO NOT WANT MY CHILD TO PARTICIPATE. I have read the above information and I* ***DO NOT*** *give permission for my child to participate in the evaluation of the after-school program.*

_____
Signature Date

If you have any questions about the evaluation contact LeSohn Reagans, Rising Stars Program Coordinator at 212-828-6132.

Health Record for Children in Day Camps, After School, and Youth Centers

(This side to be filled in by parent before presentation to physician)

Name of program_____

_____ _____ ____/____/____ _____

Child's Last Name First Name Birth Date Sex

Home Address:_____ Phone:_____

Parent or Guardian:_____ Phone:_____

Place of Employment: Father (Guardian) _____ Phone:_____

Mother (Guardian) _____ Phone:_____

In case of emergency, notify:_____ Phone:_____

If Parent/Guardian are not available in an emergency, notify:

1._____ Phone:_____

or 2._____ Phone:_____

Important: Has this camper been exposed to any communicable disease during the three weeks prior to camp attendance:

Yes No (If yes, state type of expose:_____)

Health History: (Check, giving approximate dates)

Ear Infections_____	Hay Fever_____	Chicken Pox_____
Rheumatic Fever_____	Ivy Poisoning, etc._____	Measles_____
Convulsion_____	Insect Stings_____	German Measles_____
Diabetes_____	Penicillin_____	Mumps_____
Behavior_____	Other Drugs_____	Other Contagious Illness_____
Asthma_____		

Other Past Illnesses_____

Operations or Serious Injuries (Dates)_____

Hospitalizations (Dates)_____

Chronic or Recurring Illness_____

Any specific activities to be encouraged?_____

Conditions that require activity to be restricted?_____

Permission for all program activities unless otherwise noted by Dr._____

Appliance worn (glasses, contacts, etc.)_____

Medication Taken_____

Suggested from Parent/Guardian_____

Consent for Emergency Medical Treatment

I do hereby give authority to the Day Camp and Year Round After School and Youth Center Program staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible

Relationship_____ Signature_____ Date_____ Tele#_____

Physical Examination

(To be filled out by Physician – please note information on reverse side)

The purpose of this health record is to provide the staff with pertinent information which will help to serve the needs of this child in Day Camps, After School and Youth Center programs.

Immunization History – This is a record of dates of basic immunization and most recent booster doses

DPaP, DTP, or TD	Date_____	Date_____	Date_____	Date_____	Date_____
Polio	Date_____	Date_____	Date_____	Date_____	Date_____
MMR	Date_____	Date_____	Date_____	Date_____	Date_____
Hemophilus Influenza type b					
Hepatitis B	Date_____	Date_____	Date_____	Date_____	Date_____
Varicella	Date_____	Date_____			
Other_____				Date_____	Date_____

Medical Examination – To be filled out by licensed physician

Examination is acceptable when preformed no more then 12 months prior to arrival at camp

Code: S = Satisfactory
X = Not Satisfactory (Explain)
0 = Not Examined

General
Appearance_____
Height_____ Weight_____ Blood Pressure_____ Hgb. Tes: (Date)_____
Urinalysis (Date)_____ Posture & Spine_____ Throat – Tonsils_____
Eyes_____ Vision_____ w/Glasses_____ Extremities_____ Heart_____
Ears_____ Hearing_____ Feet_____ Lungs_____ Skin_____
Nose_____ Teeth_____ Abdomen_____ Hernia_____
Genitalia_____
Neurological Findings_____
Describe Abdominal Findings and/or Handicapping Conditions_____
_____
Has child ever received products containing horse serum?_____
Allergy: (Please specify)_____
Recommendations and restrictions while in camp.

Special Diet_____
Special Medicine (name it)_____
Is parent/guardian sending special medicine?_____
Swimming_____ Diving_____
Activity Restrictions_____

General Appraisal:_____
_____
_____

I have examined the person herein described, reviewed his/her health history and it is my opinion that he/she is physically able to engage in Day Camp/Year Round, After School and Youth Center activities, except as noted above

_____M.D.
Examining Physician (Signature)

_____
Physician's Name (Please Print)

Telephone_____ Address_____
Date of Examination_____ Zip Code_____