Summer Adventures and Immersive Learning Program:

L.E.S. HEROES

A Collaboration between The Educational Alliance, Boys and Girls Clubs of America, COMPASS and TSMS

CAMP LOCATION TO BE ANNOUNCED

Academic
Enrichment

6th-8th GRADE
MONDAY-THURSDAY 9AM-5PM

PROGRAM DURATION: Monday, July 8th, 2019-Thursday, August 8th, 2019

Application must be returned or picked up from Essence Bowens of Educational Alliance or drop them off in our office 600 E 6th St, NY, NY 10009: Room #351 Monday-Friday 10:30AM-6:00PM or you can email them to phoenixclubhouse@edalliance.org

Applications will only be accepted with updated physical examination documentation.

REGISTRATION DEADLINE: May 31st, 2019
Mandatory Parent Orientation to be communicated in June

***WE ARE ACCEPTING 120 STUDENTS ON A FIRST COME-FIRST SERVE BASIS***

Contact Information:
Essence Bowens, BGCA Program Director
Email: EBowens@edalliance.org
EARLY ARRIVAL & LATE PICK-UP INTEREST FORM

The Phoenix Clubhouse offers early arrival and late pick-up at our site, if interested. Early arrivals will be no earlier than 9:00 AM and late pick-up is no later than 5:00 PM.

Indicate with a check the statement that best describes your situation:

_____ : My child will be dropped off at 9:00 AM

_____ : My child will be picked up at 5:00 PM

_____ : My child will be interested in both early arrival and late pick-up.

_____ : My child will just attend camp during the regular hours 10 AM-4 PM.

SUMMER SCHOOL INDICATION FORM

Indicate with a check the statement that best describes your situation:

_____ : My child WILL be attending summer school. My child’s expected arrival at camp is: ___ : ___ PM.

____ : My child is NOT enrolled in summer school.

___ : Not Sure.
DYCD Universal Participant Intake: Youth & Adult Application

Welcome to the Department of Youth and Community Development (DYCD)! DYCD is a New York City agency that funds programs for youth and families. These programs are operated by Community Based Organizations (CBOs). This form will allow you or your child to apply to a DYCD Comprehensive Afterschool System (COMPASS), Beacon, or Cornerstone youth or adult program. Please complete this form fully and return to the CBO that operates the program. One application will be accepted per person per site. Submission of an application does not guarantee enrollment in the program. Further paperwork and information may be required to determine program eligibility. If accepted, program will be at no cost to the participant. The following application items are collected for informational and program planning purposes only: Income, Gender, Race, Ethnicity, Language, Population Type, Household Information and Health Insurance Status. Responses to these questions will not impact your eligibility to receive services and will not be shared outside of DYCD without the applicant’s permission.

Part I: Applicant Information

For the purposes of this application, applicant refers to the person applying to receive services. Select one:

- [ ] I am completing this application for myself
- [ ] I am a parent or guardian completing this application for my child
- [ ] I am a relative/non-relative, completing this application on behalf of the applicant

<table>
<thead>
<tr>
<th>Applicant’s First Name:</th>
<th>Applicant’s Last Name:</th>
<th>MI:</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Applicant’s Date of Birth (MM/DD/YEAR):</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Applicant’s Gender (Select One):</th>
<th>Applicant’s Race (Select all that Apply):</th>
<th>Applicant’s Ethnicity (Select One):</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Male</td>
<td>[ ] American Indian and Alaskan Native</td>
<td>[ ] Hispanic or Latino(a)</td>
</tr>
<tr>
<td>[ ] Female</td>
<td>[ ] Asian</td>
<td>[ ] Not Hispanic or Latino(a)</td>
</tr>
<tr>
<td>[ ] Gender Nonconforming</td>
<td>[ ] Black or African-American</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[ ] Native Hawaiian and Other Pacific Islander</td>
<td></td>
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<tr>
<td></td>
<td>[ ] White or Caucasian</td>
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<tr>
<td></td>
<td>[ ] Other</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Applicant’s Primary Address (Number and Street):</th>
<th>Apt. Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| City:                                          | Zip Code:    |
|                                               |              |

[ ] Applicant lives in a NYCHA Development (please provide name)
## Part II: Contact Information

### Applicant's Contact Information

For youth without contact information, skip to the next section to provide parent/guardian contact information.

Write down phone numbers for the applicant and circle the preferred method of contact:

- [ ] Home ______________________  [ ] Cell ______________________
- [ ] Work _______________________  [ ] Email ______________________
  [ ] No Email

### Parent/Guardian Information

This section is required for Applicants under 18.

Parent/Guardian Name: ________________________________

Write down all phone numbers and circle the best number to call in case of an emergency:

- [ ] Home ______________________  [ ] Cell ______________________
- [ ] Work _______________________  [ ] Email ______________________
  [ ] No Email

Address: ________________________________

[ ] Same as Participant

City: __________________ State: ______ Zip Code: ______

### Emergency Contact Information

At least one emergency contact must be identified.

<table>
<thead>
<tr>
<th>Emergency Contact #1 Name:</th>
<th>Relationship to Participant:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ] Emergency contact is parent/guardian of participant</td>
</tr>
</tbody>
</table>

Write down all phone numbers and circle the best number to call in case of an emergency:

- [ ] Home ______________________  [ ] Cell ______________________
- [ ] Work _______________________  [ ] Email ______________________
  [ ] No Email

Address: ________________________________

[ ] Same as Participant

City: __________________ State: ______ Zip Code: ______

<table>
<thead>
<tr>
<th>Emergency Contact #2 Name:</th>
<th>Relationship to Participant:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ] Emergency contact is parent/guardian of participant</td>
</tr>
</tbody>
</table>

Write down all phone numbers and circle the best number to call in case of an emergency:

- [ ] Home ______________________  [ ] Cell ______________________
- [ ] Work _______________________  [ ] Email ______________________
  [ ] No Email

Address: ________________________________

[ ] Same as Participant

City: __________________ State: ______ Zip Code: ______
This section is for parents/guardians enrolling their children.

Emergency contacts listed in Section II are authorized to pick up the child unless otherwise noted.

The following additional people are authorized to pick up my child:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Phone #:</th>
<th>Relationship:</th>
</tr>
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<tbody>
<tr>
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</tbody>
</table>

The following people **MAY NOT** pick up my child:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Part III: Applicant’s Education/Work Status

Applicant’s Education Status (Select One):
- [ ] Full-Time Student***
- [ ] Part-Time Student***
- [ ] Not in School****

***If applicant is a Part-Time Student or Full-Time Student: Select applicant’s current grade (Select One):
- [ ] Pre-K
- [ ] K
- [ ] 1st
- [ ] 2nd
- [ ] 3rd
- [ ] 4th
- [ ] 5th
- [ ] 6th
- [ ] 7th
- [ ] 8th
- [ ] 9th
- [ ] 10th
- [ ] 11th
- [ ] 12th

****If applicant is Not in School: Select the last grade completed by the applicant (Select One):
- [ ] Elementary School:
- [ ] Pre-K
- [ ] K
- [ ] 1st
- [ ] 2nd
- [ ] 3rd
- [ ] 4th
- [ ] 5th
- [ ] 6th
- [ ] 7th
- [ ] 8th

- [ ] Middle School:
- [ ] 6th
- [ ] 7th
- [ ] 8th
- [ ] 9th
- [ ] 10th
- [ ] 11th
- [ ] 12th

- [ ] High School:
- [ ] 1st
- [ ] 2nd
- [ ] 3rd
- [ ] 4th
- [ ] 5th
- [ ] 6th
- [ ] 7th
- [ ] 8th
- [ ] 9th
- [ ] 10th
- [ ] 11th
- [ ] 12th

- [ ] Community College:
- [ ] Associate
- [ ] Bachelor
- [ ] Master
- [ ] Doctorate
- [ ] Other

- [ ] College/University:
- [ ] Freshman
- [ ] Sophomore
- [ ] Junior
- [ ] Senior

- [ ] High School Equivalence (HSE)
- [ ] Vocational/Trade School
- [ ] Foreign Degree

Applicant’s Current Work Status (Select One):
- [ ] Employed Full-Time
- [ ] Employed Part-Time
- [ ] Unemployed (Short-Term, 6 months or less)
- [ ] Unemployed (Long-term, more than 6 months)
- [ ] Migrant Seasonal Farm Worker
- [ ] Not applicable (applicant is under 14 years of age)
- [ ] Retired
- [ ] Unemployed (Not in labor force)

Required for Full-Time Students

<table>
<thead>
<tr>
<th>Student ID/ OSIS:</th>
<th>School Type:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ] Public [ ] Charter [ ] Private [ ] Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>School Name:</th>
<th>City:</th>
<th>Zip Code:</th>
</tr>
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</table>
### Part IV: Health Information

**Applicant's Health Information**

Please answer the questions below and provide additional details in the space provided. Many needs or health challenges can be accommodated and may not limit enrollment in the program.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Decline to Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the applicant have any allergies? (food, medication, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>Does the applicant have asthma?</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>Does the applicant have special health care needs?</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>Does the applicant take medication for any condition or illness?</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>Are there activities the applicant cannot participate in?</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
</tbody>
</table>

Please provide any additional health information details:

☐ N/A

Please list any accommodation(s) you are requesting for yourself/the applicant:

☐ N/A

### Applicant's Health Insurance Status

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Decline to Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the applicant have health insurance? (Select One):</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Decline to Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, what kind of health insurance does the applicant have? (Check all that Apply):</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>□ Medicaid</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>□ Employment-Based</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>□ Military Health Care</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>□ Medicare</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>□ Direct-Purchase</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>□ State Children's Health Insurance Program</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>□ State Children's Health Insurance for Adults</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

If you do not have health insurance, do you want to be contacted by someone else with information about signing up for public health insurance? (Select One):

☐ Yes ☐ No ☑ Decline to Answer

If you would like to be contacted about signing up for public health insurance, what is your preferred method of contact? (Select One):

☐ Email ☐ Phone ☐ US Mail ☐ Via provider ☑ Decline to Answer
# Part V: Additional Applicant Information

## How well does the applicant speak English? (Select One):
- [ ] Fluent/Very well
- [ ] Well
- [ ] Not well
- [ ] Not well at all

## Applicant's Primary Language (Select One):

- [ ] English
- [ ] Bengali
- [ ] Fulani
- [ ] Haitian Creole
- [ ] Hungarian
- [ ] Korean
- [ ] Punjabi
- [ ] Portuguese
- [ ] Spanish
- [ ] Urdu
- [ ] Albanian
- [ ] Chinese*
- [ ] German
- [ ] Hebrew
- [ ] Italian
- [ ] Kru, Ibo, or Yoruba
- [ ] Romanian
- [ ] Tagalog
- [ ] Vietnamese
- [ ] Arabic
- [ ] French
- [ ] Gujarati
- [ ] Hindi
- [ ] Japanese
- [ ] Mande
- [ ] Polish
- [ ] Russian
- [ ] Turkish
- [ ] Yiddish

- [ ] Other: ____________________________

*Including Cantonese and Mandarin

## Other Languages Spoken by Applicant (Select all that Apply):

- [ ] English
- [ ] Bengali
- [ ] Fulani
- [ ] Haitian Creole
- [ ] Hungarian
- [ ] Korean
- [ ] Punjabi
- [ ] Portuguese
- [ ] Spanish
- [ ] Urdu
- [ ] Albanian
- [ ] Chinese*
- [ ] German
- [ ] Hebrew
- [ ] Italian
- [ ] Kru, Ibo, or Yoruba
- [ ] Romanian
- [ ] Tagalog
- [ ] Vietnamese
- [ ] Arabic
- [ ] French
- [ ] Gujarati
- [ ] Hindi
- [ ] Japanese
- [ ] Mande
- [ ] Polish
- [ ] Russian
- [ ] Turkish
- [ ] Yiddish

- [ ] Other: ____________________________

*Including Cantonese and Mandarin

## Would the applicant like to receive information/be contacted about registering to vote?** (Select One):
- [ ] Yes
- [ ] No

**Applicant is eligible to vote in U.S. federal elections if:
1) You are a U.S. citizen;
2) You meet your state’s residency requirements;
3) You are 18 years old. Some states allow 17-year-olds to vote in primaries and/or register to vote if they will be 18 before the general election. Check your state’s voter registration age requirements.

## Is the applicant any of the following:

- Parent/Legal Guardian? □ Yes □ No
- Offender/Justice Involved? □ Yes □ No
- Foster Care Participant? □ Yes □ No
- Runaway Youth? □ Yes □ No
- Veteran? □ Yes □ No
- Active Military Personnel? □ Yes □ No
- An Individual with a Disability? □ Yes □ No □ Decline to answer

## If the applicant is an individual with a disability, please select disability type(s) (Select all that Apply):

- [ ] Cognitive impairment
- [ ] Hearing-related
- [ ] Learning disability
- [ ] Mental or Psychiatric
- [ ] Physical/Chronic Health Condition
- [ ] Physical/Mobility Impairment
- [ ] Vision-related
- [ ] Other: ____________________________

[ ] Decline to Answer
### Part VI: Household Information

For all the next set of questions, **HOUSEHOLD** is defined as any individual or group of individuals (family or non-family members) who are living together as one economic unit. **INCOME** is defined as the total annual gross income of all family and non-family members 18+ years old living within the household.

#### The applicant lives in a household that is headed by

(Select One):
- Single Parent - Female
- Single Parent - Male
- Single Person - No children
- Non-related adults with children
- Two Adults - No Children
- Two Parent Household
- Multigenerational Household
- Other: ________________________

#### Applicant's Housing Type (Select One):
- Own
- Rent
- NYCHA
- Shelter
- Homeless
- Other Permanent Housing
- Other: ________________________

#### Applicant's Household Size (Select One):
- One
- Two
- Three
- Four
- Five
- Six
- Seven
- Eight
- Nine
- Ten
- Eleven
- Twelve
- Thirteen
- Fourteen
- Fifteen
- Sixteen
- Seventeen
- Eighteen
- Nineteen
- Twenty+

#### Total Household Income in the last 12 Months (Select One):
- $0
- $1,241 to $20,420
- $20,421 to $28,780
- $28,781 to $32,990
- $32,991 to $37,140
- $37,141 to $41,320
- $41,321 to $50,000
- $50,001 to $60,000
- $60,001 to $70,000
- $70,001 to $80,000
- $80,001 to $90,000
- $90,001 to $100,000
- $100,000+
- Decline to Answer

#### Sources of Applicant's Household Income (Select all that Apply):
- Employment Wages
- Childcare Voucher
- Housing Choice Voucher
- Permanent Supportive Housing
- Retirement Income from Social Security
- Temporary Assistance for Needy Families (TANF)
- Affordable Care Act Subsidy
- Earned Income Tax Credit (EITC)
- HUD-VASH
- Private Disability Insurance
- Social Security Disability Income (SSDI)
- Unemployment Insurance
- Worker’s Compensation
- Alimony or other Spousal Support
- Employment Tax Credit
- LIHEAP
- Public Housing
- Supplemental Security Income (SSI)
- VA Non-Service Connected Disability Pension
- Other: ________________________
- Decline to Answer

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Universal Participant Intake: Youth & Adult Application / Page 6 of 9
Part VII: Consents and Signatures

Pick-up/Dismissal Information
This question must be answered for parents/guardians enrolling their children
My child has permission to travel home alone at dismissal:

☐ Yes  ☐ No

Consent to Participate
To the best of my knowledge the information above is true. I agree to its verification and understand that falsification may be grounds for termination of service. Information provided may be used by the City of New York to improve City services and access to those services, and to access additional funding.

If participant is 18 and over:
I acknowledge that I am 18 years of age or older and am authorized to give consent.

☐ Yes  ☐ No

Participant’s Signature  Participant: Print Name  Date

If participant is under 18 years old:

Parent/Guardian’s Signature  Parent/Guardian: Print Name  Date

Consent for Emergency Medical Treatment
If participant is 18 and over
I am enrolled as a participant in a DYCD-funded program. In the event of a medical emergency, I hereby give consent for necessary emergency medical treatment to be obtained on my behalf. I further authorize the emergency contact(s) listed to be contacted.

☐ Yes, I give my permission  ☐ No, I do not give permission

Participant’s Signature  Participant: Print Name  Date

If participant is under 18 years old:
My child is enrolled as a participant in a DYCD-funded program. In the event of a medical emergency, I hereby give consent for necessary emergency medical treatment for my child to be obtained, with the understanding that I will be notified as soon as possible. I understand that every effort will be made to contact me, or, if I am unavailable, the emergency contact(s) listed, before and after medical care is provided.

☐ Yes, I give my permission  ☐ No, I do not give permission

Parent/Guardian’s Signature  Parent/Guardian: Print Name  Date
Consent for Photography/Videotaping and Use of Original Work

As a participant enrolled in a DYCD-funded program, please be aware that from time to time DYCD and the City of New York, its contracted providers, authorized agents, third-party organizations with which it collaborates, or other government, representatives (collectively, "Authorized Parties") may be present during program activities and special events associated with program services, both at the usual program location and at off-site events. In some cases, they may photograph, videotape, interview or otherwise record participants and their families and friends in these programs. The resulting images, videos, and interviews may be used, with or without the participant’s name, in printed and electronic media such as brochures, books, print and email newsletters, DVDs and videos, websites, social media and blogs (collectively, "Media").

I hereby authorize and permit the Authorized Parties, without compensation and without further approval, to photograph and/or record my and my child’s image, name, likeness, and the sound of my and my child’s voice during DYCD-funded program activities and special events, and I hereby consent to the resulting images, videos and interviews being used, without compensation and without further approval by the Authorized Parties solely for non-profit, non-commercial purposes in any and all Media.

☐ Yes  ☐ No

If, in the course of participating in DYCD-funded program activities and special events, any original work such as art, music, choreography, poetry, or prose (collectively, "Original Work") is created by me or my child, I hereby consent to such Original Work being used by the Authorized Parties, without compensation and without further approval, solely for non-profit, non-commercial purposes in any and all Media.

☐ Yes  ☐ No

If participant is 18 and over:

I acknowledge that I am 18 years of age or older and am authorized to give consent.

☐ Yes  ☐ No

Full Name of Participant  Participant’s Signature  Date

If participant is under 18 years old:

Full Name of Participant  Parent/Guardian’s Signature  Date
Parent/Guardian Consent to Collect and Share Student Information

The Department of Youth and Community Development (DYCD) provides funding for this program as part of its mission to help you assist your child reach his or her full potential. Many of our programs are run by community based organizations. We work to make sure the services you and your children receive are of the highest quality. DYCD is requesting your permission to allow us to collect information we need on your child, their participation and the quality of the services provided.

What information from your child's student records is DYCD requesting?
We are requesting your permission for the NYC Department of Education (DOE) to share personally identifiable information from your child's student records with DYCD. The information we would like to collect consists of biographical and enrollment information (specifically consisting of your child's name, address, date of birth, student identification number, grade, school(s) attended and transfer, discharge, and graduation data about your child); data concerning your child's school attendance (including number of days attended and absences); and academic performance data (including your child's results on state and national exams, credits earned, grades, promotion and retention status, and fitnessgram score); and data related to any disciplinary actions taken against your child (including number and type of suspensions).

We are requesting to collect the information listed above about your child on a past, present and future (i.e., ongoing) basis.
We are also requesting your permission for DYCD to share information we collect on the enrollment form from you and/or your child with DOE staff. The information includes registration information, student's interests and challenges, type of program enrolled-in and frequency of participation. This information will be used to help the school and community organization work together to meet you and your child's needs.

Who will see my child’s information and how will it be safeguarded?
The only people who will see your child's individual information are DYCD and DOE staff who manage the data systems and prepare research reports and program analyses. The limited number of DYCD staff identified to receive personal information is screened, and provided extensively trained to follow strict guidelines on protecting the confidentiality of information that would personally identify you or your child. Personally identifiable information collected from student records will only be shared electronically between DOE and DYCD and will be secured and protected in the DYCD data base. Personally identifiable information will not be shared with any community based organizations or their staff members. We will not use your name or your child’s name in any published report. While we request your consent, your responses to the below requests will not affect your child's participation in DYCD sponsored programs.

Please check Yes or No to each of the following statements:
I understand why DYCD is asking my permission to access the information listed above from my child’s student records, and I give my permission to DOE to share that information with DYCD on an ongoing basis.

☐ Yes, I give my permission ☐ No, I do not give my permission

I understand why DYCD is asking my permission to share information about my child collected by DYCD with DOE staff and I give my permission to DYCD to share information with DOE on an ongoing basis.

☐ Yes, I give my permission ☐ No, I do not give my permission

Student/Applicant Name: ____________________________________________

Parent/Guardian Name: ____________________________________________

Parent/Guardian Signature: _________________________________________ Date: ______________

Additional Parent/Guardian Name (optional): ___________________________

Additional Parent/Guardian Signature (optional): __________________________
Health Information

* To be completed by the parent/guardian. This confidential health information will only be used to ensure the safety of the children in this program.

** Please provide your child's medical history:

- Allergies to food:
  - Yes
  - No

- Allergies to peanuts:
  - Yes
  - No

- Allergies to tree nuts:
  - Yes
  - No

- Allergies to dairy:
  - Yes
  - No

- Allergies to eggs:
  - Yes
  - No

- Allergies to sulfites:
  - Yes
  - No

- Asthma:
  - Yes
  - No

- Convulsions/Seizures:
  - Yes
  - No

- Allergy to insect stings:
  - Yes
  - No

- Diabetes:
  - Yes
  - No

- Hay Fever:
  - Yes
  - No

- Other:
  - Yes
  - No

- Corrective Device:
  - Yes
  - No

- Physical Disabilities:
  - Yes
  - No

- Behavioral/Emotional:
  - Yes
  - No

- Other:
  - Yes
  - No

Please select the following options if applicable:

- Allergy to cats:
  - Yes
  - No

- Allergy to dogs:
  - Yes
  - No

- Allergy to feathers:
  - Yes
  - No

- Allergy to pollen:
  - Yes
  - No

- Allergy to seafood:
  - Yes
  - No

- Allergy to shellfish:
  - Yes
  - No

- Other:
  - Yes
  - No

Are there any activities your child cannot participate in:

- Yes
  - No

Please explain:

Does your child take medication for any condition or illness?

- Yes
  - No

Does your child have special health care needs that require treatment or medication?

- Yes
  - No

- Specify:
  - Yes
  - No

** Please sign this form and continue as long as your child is enrolled in this program.

Date

Student Name:
**Consent to Photograph, Film, or Videotape a Student for Non-Profit Use**  
(E.G., Educational, Public Service or Health Awareness Purposes)

<table>
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<tr>
<th>Student Name:</th>
<th>School:</th>
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I hereby consent to the participation in interviews, the use of quotes, and the taking of photographs, movies or videotapes of the Student named above by the New York City Department of Education. I also grant to the New York City Department of Education the right to edit, use, and reuse said products for non-profit purposes including use in print, on the internet, and all other forms of media. I also hereby release the New York City Department of Education and its agents and employees from all claims, demands, and liabilities whatsoever in connection with the above.

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<tr>
<th>Parent/Guardian Name (Print)</th>
<th>Parent/Guardian Signature</th>
<th>Date</th>
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Address of Parent/Guardian: ____________________________
Student Data and Evaluation Consent Form

Your child, ____________________________________________, is enrolled in the program funded by the 21st Century Community Learning Center grant (21st CCLC). In order to monitor the effectiveness of the program and ensure its future success, an independent evaluator is conducting an ongoing evaluation. It the intentions 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 to:

- Obtain demographic data including: racial/ethnic group, gender, grade level, English proficiency, free or reduced price lunch eligibility, and special needs from the New York City Department of Education for students in the 21st CCLC program.
- Contact your child’s school to obtain records showing his or her progress, including information about enrollment, grades, citywide and statewide test scores, and 21st CCLC program attendance.
- Survey and/or interview you and your child about the 21st CCLC program and its effects.
- Talk to teachers and staff about your child’s progress and participation in the 21st CCLC program, and review program records on participation in the program.

Individual student data we collect will only be used to assess the 21st CCLC program and will not be made public. Participating in the evaluation will not affect your child in school, in the 21st CCLC 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 anytime 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 21st CCLC program. I also consent for the evaluator and the New York City Department of Education to obtain my child’s records, interview program and school staff, and interview me and my child for evaluation purposes.

_____ 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 21st CCLC program.

If at any time you change your mind about this decision, you may contact the site coordinator and/or evaluator directly at:

Student Name: __________________________________________ Student OSIS #: ______________________

School: ________________________________________________

Parent/Guardian Name (Print) ____________________________ Parent/Guardian Signature ______________________ Date ____________
This office works with the Mental Health Service Corps (MHSC). MHSC is a New York City program that helps offices like this one provide better mental health care. The people caring for your child/youth here may include a clinician from the MHSC. The MHSC clinician can help your child/youth identify and work through things like stress, trauma, and emotional distress.

MHSC clinicians hold professional degrees in social work, psychology, or counseling. They can only provide care to your child/youth under supervision from a state-licensed Clinical Social Worker, Psychologist, Psychiatrist, or Mental Health Counselor. This MHSC supervisor is in charge of the care that your child’s/youth’s MHSC clinician provides. The MHSC supervisor will also be part of the team of people caring for your child/youth, but you may not see them in person. The supervisor’s name is at the end of this form. The MHSC clinician and MHSC supervisor will be able to see your child’s/youth’s health records at the office. They will keep these records private.

If you have questions about your child’s/youth’s care, this form, or the MHSC program, please ask. You can contact the clinician’s supervisor using the information below. You can also ask your child’s/youth’s MHSC clinician, or any other staff at the office. Make sure to ask for a copy of this form after you sign it.

Please sign below to let us know that you have read this information and understand it. If you sign, we can add a MHSC clinician and supervisor to your child’s/youth’s care team. You do not have to sign this form. If you do not sign, your child/youth will not see an MHSC clinician at this time, but they can still get other care offered at this office.

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<th>Signatures and Contact Information</th>
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<tbody>
<tr>
<td><strong>Child/Youth Name</strong></td>
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<tr>
<td><strong>Child/Youth Signature (if required)</strong></td>
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<td><strong>Parent/Guardian Name (if required)</strong></td>
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<tr>
<td><strong>MHSC Supervisor Name</strong></td>
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<td><strong>MHSC Supervisor Phone Number</strong></td>
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<td><strong>Child/Youth Date of Birth</strong></td>
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<td><strong>Today’s Date</strong></td>
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<tr>
<td><strong>Parent/Guardian Signature</strong></td>
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<tr>
<td><strong>MHSC Central Office Phone Number</strong></td>
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<tr>
<td>212-213-2638</td>
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<td><strong>MHSC Central Office Email</strong></td>
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<tr>
<td><a href="mailto:MHSC@hunter.cuny.edu">MHSC@hunter.cuny.edu</a></td>
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