BEACON
CENTER FOR ARTS & LEADERSHIP

Roland Hayes I.S. 291
231 Palmetto Street ▪ Brooklyn, NY 11221 ▪ Room 131
Beacon Office Number: 718.574.0361 Ext 131 Beacon Cell Phone Number: 646.276.4196

Afterschool Application

Valid September 14, 2015 - June 17, 2016

Aplicación para el Programa Despues de la Escuela

Valida 14 de Septiembre 2015 hasta el 17 de Junio 2016

Name: _____

Participant Grades:

☐ 5-8 Grade – Afterschool

☐ K-5 Grade - Little Leaders

A Program of

Coalition for Hispanic Family Services
Building Strong Communities One Family at a Time

www.HispanicFamilyServicesNY.org

NYC Department of Youth & Community Development

PARTICIPANT INFORMATION

1. Last Name

2. First Name

3. Middle

4. Social Security Number

5. Gender ☐ Male ☐ Female

6. Birth Date (Month / Day / Year)

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 ☐ Charter School

22. Grade:

23. Public School Student ID# (OSIS):

24. Primary Language Spoken

25. English Proficient ☐ Yes ☐ No

26. 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 ☐

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

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

29. Has the participant been enrolled in any of the following programs? ☐ 1. ACS 2. OST 3. TASC 4. Service Learning

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

If yes, please list additional children below:

31. Additional Child — Last Name | First Name

32. Additional Child — Last Name | First Name

Pick-Up Permissions

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

Child may be picked up by:

34. Last Name | 35. First Name | 36. Middle

37. Home Phone Number (Area code) - - | 38. Relationship to applicant

39. Last Name | 40. First Name | 41. Middle

42. Home Phone Number (Area code) - - | 43. Relationship to applicant

44. Last Name | 45. First Name | 46. Middle

47. Home Phone Number (Area code) - - | 48. Relationship to applicant

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

49. Last Name | 50. First Name | 51. Middle

52. Relationship to applicant (Area code)

52. Last Name | 53. First Name | 54. Middle

55. Relationship to applicant (Area code)

Please continue on the following page

Parent / Guardian Information

56. Last Name

57. First Name

58. Middle

59. Street Address (number and street)

60. Apt #

61. Zip Code

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

63. Birth Date: Month Day Year

64. Home Phone Number (Area code) - -

65. Work Phone (Area code) - -

66. Cell / Pager Number - -

67. Email Address:

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

69. Relationship to applicant

70. Primary Language Spoken

71. English Proficient Yes No

Additional Parent / Guardian Information

72. Last Name

73. First Name

74. Middle

75. Street Address (number and street)

76. Apt #

77. Zip Code

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

79. Birth Date: Month Day Year

80. Home Phone Number (Area code) - -

81. Work Phone (Area code) - -

82. Cell / Pager Number - -

83. Email Address:

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

Please continue on the following page

85. Relationship to applicant

86. Primary Language Spoken

87. English Proficient ☐ Yes ☐ No

Beacon Center for Arts & Leadership Permission Form

I authorize my son/daughter _____ to attend the Beacon Center for Arts & Leadership After-School Program, a program of Coalition for Hispanic Family Services, to participate in all after school activities Monday through Thursday from **2:30pm – 7:30pm**, Friday from **2:30pm – 6:00pm** and from **8:00am – 6:00pm** on school closing days and in the summer from **8 – 6pm**. For activities beyond what is noted above the Beacon will send home a permission slip.

In consideration of the program permitting my child to participate in program activities, I hereby release, discharge, and agree to indemnify and hold harmless, the Beacon Center for Arts & Leadership, its directors, organizers, sponsors, staff, volunteers and agents from all claims, liabilities, or cases of action arising out of such treatment and with respect to the exercise of its judgment in this regard. I further attest that I have disclosed all vital and important health information (allergies, medications, and medical limitations on activities) which would be necessary for the proper care of my child.

I also authorize the program to obtain copies of my child's report cards from his/her school and also authorize the staff of the program to speak to my child's public school teacher regarding his/her academic behavior.

I also authorize my child to receive counseling from the staff Art Therapist if deemed necessary by the Beacon Staff.

I agree to attend a mandatory parent orientation to be informed of the after-school rules and regulations. I understand that if I do not attend the parent's orientation, I forfeit my child's spot in the program.

_____ _____

Signature of Parent/Guardian Date

DEPARTMENT OF YOUTH AND COMMUNITY DEVELOPMENT
BEACON PROGRAM

Agency: CHFS

School: I.S. 291

Photo/Video Consent Form (To be completed by the parent or guardian)

I certify that I am the parent or legal guardian of _____ whose date of birth is _____
(Child's Name) (Birthday date)

I understand that _____ staff, as well as photographers, newspaper and television reporters,
(Agency)
media representatives and public relations personnel may be present during program activities and special events both in-school and away from school. In some cases, they may photograph, interview or otherwise record children who participate in these activities and events. The resulting images, videos, and interviews may be used to promote the programs in printed and electronic media published by our agency, such as brochures, books, print and email newsletter, DVDs and videos, websites and blogs. These images, videos and interviews may also be used by New York City's Department of Youth and Community Development (DYCD) in its publications.

I give permission for my child to be photographed, interviewed or otherwise recorded during program activities and special events, and for the resulting images and text to be used by Coalition for Hispanic Family Services or DYCD in any medium, whether now or hereafter known or developed.

Signature of Parent/Guardian: _____ Date: _____

If you <u>do not</u> wish for your children to participate in interviews or the recording of images as described above, please review this section of the form.

I **DO NOT** give permission for photographs, other recordings or interviews of my child to be used by the program or DYCD in any publication. As a result, my child may not be able to participate in events and group activities that may be used for publication purposes.

Signature of Parent/Guardian: _____ Date: _____

Please continue on the following page

POLICY STUDIES ASSOCIATES, INC.
1718 CONNECTICUT AVENUE, N.W. • SUITE 400 • WASHINGTON, D.C. 20009
(202) 939-9780 • (202) 939-5732 FAX • WWW.POLICYSTUDIES.COM

Parent Consent to Participate in the
Evaluation of the Beacon Community Center Middle School Initiative

Dear Parent,
Your child, _____, is enrolled in the Beacon program at **I.S 291** , which is supported by Department of Youth and Community Development (DYCD). In order to monitor the effectiveness of the Beacons Middle School Initiative and ensure its future success, DYCD has contracted with Policy Studies Associates (PSA) to conduct an ongoing evaluation. It is the intention of the evaluation to learn how these services help students and how they can be improved.

We ask permission from parents to:

- Survey and interview children about the Beacon program and its effects. Participants will be given a four - page survey to complete about their experiences at the Beacon program.
- Review program records on your child's participation in the Beacon program.
- Request from the Department of Education (DOE) student records, including: information about enrollment, citywide and statewide test scores, and attendance.

Any information we collect will be used only to assess the Beacon program and will not be made public. Participating in the evaluation will not affect your child in school, in the Beacon 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 Beacon 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 Beacon program.*

_____

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 Beacon program.*

_____

Signature

Please continue on the following page

Department of Youth & Community Development

Agency: Coalition for Hispanic Family Services

School: I.S. 291 (Beacon)

Parent Consent for Participation in Data Collection

Dear Parent:

Your child, _____, is enrolled in a program at _____ which is supported by the Department of Youth and Community Development (DYCD). In order to monitor the effectiveness of this program and ensure its future success, DYCD is collecting information about participants' experiences in the program. This information will help DYCD learn how the program helps students and how it can be improved. This project has been approved by the Department of Education.

Specifically we ask permission from parents to:

- Survey children about the DYCD program.

Any information we collect will be used only to assess the DYCD program and will not be made public. Participating in the evaluation will not affect your child in school, in the program, or in any other way. We will not use your name or your child's name in any report. Participation is completely voluntary and participants may withdraw at any time with no consequences.

Please select one of the options below.

You only need to complete and return this form if you select "No, I do not want my child to participate."

☐ *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 DYCD survey.*

_____

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 DYCD data collection activities.*

_____

Signature Date

If you have any questions or concerns, please contact the Director of Beacon Programs, Wanda Ascherl at 212-227-7043 or wascherl@dycd.nyc.gov .

Health Record Information

This document must be completed by participant or guardian. Providing this information will help us assist you or your child in the event of an emergency. The physical examination is optional during after school hours however mandatory for summer camp.

Name of program: _____ Beacon _____

Name of child: _____ _____/_____/_____ ☐ M ☐ F

Birthdate *Sex*

Child's address: _____ Phone: _____

Name of Parent/guardian: _____ Phone: _____

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

Mother (Guardian) _____ Phone: _____

In case of emergency, notify: _____ Phone: _____

If parent or guardian are not available in an emergency, notify:

1. _____ Phone: _____

2. _____ Phone: _____

Important: Has this child been exposed to any communicable disease during the three weeks prior to beginning program?

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

Health history: (Check, giving approximate dates)

Allergies

Hay Fever _____
Ivy poisoning, etc. _____
Insect stings _____
Penicillin _____
Other drugs _____

Diseases

Chicken Pox _____
Measles _____
German Measles _____
Mumps _____
Other contagious illnesses _____

Ear Infections _____
Rheumatic Fever _____
Convulsion _____
Diabetes _____
Behavior _____
Asthma _____

Other past illnesses _____
Operations of serious injuries (dates) _____
Hospitalization (dates) _____
Chronic or recurring illness _____
Conditions that require activity to be restricted? _____
Appliance worn (glasses, contacts, etc.) _____
Medication taken _____
Insurance Carrier: _____ **I.D.# / Medicaid #:** _____

Providing this information will help us assist your child in the event of an emergency.

Consent for Emergency Medical Treatment

I do hereby give authority to the Beacon staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

_____ _____ _____

Signature *Relationship* *Date*