

New York State 21st Century Community Learning Centers (CCLC)

Program Name:

Enrollment Form

School Year:

PHOTO OF CHILD (Optional)	Student's Full Name: Preferred Name:		Date of Birth:	Gender:	
	Student's Home Address:				
	Home Phone:		Language(s) Spoken at Home:		
	Racial/Ethnic Group: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Two or more races <input type="checkbox"/> Other _____				
	Student ID Number (to be completed by Program): <input type="checkbox"/> NYSED ID <input type="checkbox"/> District ID		Attending School:		Grade:
	Student's Primary Teacher (Required for Students in Grades 1-5 only) Indicate N/A if not applicable				
	Name of Person Enrolling Student:		Relationship to Student: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Caretaker <input type="checkbox"/> Relative <input type="checkbox"/> Other _____		
	Address of Person Enrolling Student (if different than student):				
Phone Number(s) of Person Enrolling student: Email:					

Emergency Contact Names	Authorized to Pick Up	Primary Phone Number	Other Phone Number/Email
Primary Contact:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Primary Contact:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Secondary Contact:	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Release of Student at Dismissal

I give my child permission to walk alone at dismissal: <input type="checkbox"/> Yes <input type="checkbox"/> No		
If no, my child will be picked up afterschool by me or one of the following individuals:		
Name:	Phone:	Relationship to Student:
Name:	Phone:	Relationship to Student:

My child MAY NOT be picked by the following individuals:

Name:	Relationship to Student:
Name:	Relationship to Student:
Name:	Relationship to Student:

Release of Student During Medical Emergencies

If I am not available during emergencies, my child may be released to one of the following individuals:

Name:	Phone:	Relationship to Student:
Name:	Phone:	Relationship to Student:

Student's Health Information

All information is confidential and is used by the program staff to ensure the safety of students.

Does your child have any of the following?

Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list what child is allergic to: If yes, does your child need/use an EpiPen? <input type="checkbox"/> Yes* <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, does your child use an inhaler or other medicine for his/her asthma? <input type="checkbox"/> Yes* <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, does your child need medication or blood glucose monitoring? <input type="checkbox"/> Yes* <input type="checkbox"/> No If yes, does your child have a prescription for glucagon? <input type="checkbox"/> Yes* <input type="checkbox"/> No
Seizure Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, does your child need medication for preventing or treating seizures? <input type="checkbox"/> Yes* <input type="checkbox"/> No
Vision Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, and your child needs aids at school other than wearing glasses or contacts, please describe:
Hearing Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, and your child needs aids at school other than wearing a hearing aid, please describe:
Physical Limitations	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is your child able to participate in physical education class at school with no limitations? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please list his/her activity limitations:
Other Medication(s)	<input type="checkbox"/> Yes* <input type="checkbox"/> No	If yes, please list:

Does your child have special diet needs, other health needs, or behavioral/emotional needs?
If yes, please describe:

**Please note medications taken or administered at the program will need written parent/guardian consent and health care provider order. Please check with program director/site coordinator for details.*

Agreements

I give my child permission to enroll and participate in the 21st CCLC program Yes No

I understand that following agreements and consents **are not pre-conditions for approval** to participate in the 21st CCLC program.
 Yes No

I consent to emergency medical treatment for my child Yes No

I consent for my child to participate in interviews, the use of quotes, and the taking of photographs, movies, or videotapes by the [Program Name]. I also grant [Program Name] 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 [Program Name] and its agents and employees from all claims, demands, and liabilities whatsoever in connection with the above. Yes No

I consent for my child to take part in field trips, away from the program site, under supervision. Yes No

I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips. Yes No

I provided information on my child's special needs to the program to assist in the safety of my child. Yes No

I understand that information regarding my child's special learning needs will be shared by my child's school of enrollment with 21st CCLC program staff on a need-to-know basis for my child's educational benefit Yes No

I agree to review and update this information whenever a change occurs and at least once every year. Yes No

I agree to talk to the program staff about my child's progress and participation in the 21st CCLC program. Yes No

If at any time I change my mind about my child's participation (any or all aspects), I will contact the site coordinator. Yes No

Student Data Requirements and Surveys/Interviews Consent

I understand that my child's academic, behavioral, attendance, and engagement information will be shared with the New York State Education Department and its lawful contractors, to measure and evaluate the quality and implementation of the local 21st Century Community Learning Center (21st CCLC) program as well as the effectiveness New York State's program in supporting student growth, as required by Title IV, Part B of the Every Student Succeeds Act (ESSA) [see generally sections 4205 (b) and 4203 (14)].

I understand that my child and I may be asked to participate in surveys and/or interviews about the 21st CCLC program and its effects. Only check the following box if you would like to opt-out and not participate in surveys and/or interviews.

By signing below, I certify that all information (above) is true and correct to the best of my knowledge.

Name of Parent/Person in Relation/Guardian:

Signature of Parent/Person in Relation/Guardian

Date Signed