|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Student’s Full Name:  Preferred Name: | | | Date of Birth: | Gender: | |
| Student’s Home Address: | | | | | |
| Home Phone: | | Language(s) Spoken at Home: | | | |
| Racial/Ethnic Group: □ American Indian/Alaska Native □ Black or African American □ Hispanic or Latino  □ Asian □ White □ Native Hawaiian/Pacific Islander □ Two or more races □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Student ID Number *(to be completed by Program)*: □ NYSED ID □ District ID | Attending School: | | | | Grade: |
| Name of Person Enrolling Student: | Relationship to Student:  □ Parent □ Guardian □Caretaker □ Relative □ 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:** | □ Yes □ No |  |  |
| **Primary Contact:** | □ Yes □ No |  |  |
| **Secondary Contact:** | □ Yes □ No |  |  |

**Release of Student at Dismissal**

|  |  |  |
| --- | --- | --- |
| I give my child permission to walk alone at dismissal: □ Yes □ 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** | □ Yes □ No | If yes, list what child is allergic to:  If yes, does your child need/use an EpiPen? □ Yes\* □ No |
| **Asthma** | □ Yes □ No | If yes, does your child use an inhaler or other medicine for his/her asthma?  □ Yes\* □ No |
| **Diabetes** | □ Yes □ No | If yes, does your child need medication or blood glucose monitoring? □ Yes\* □ No  If yes, does your child have a prescription for glucagon? □ Yes\* □ No |
| **Seizure Disorder** | □ Yes □ No | If yes, does your child need medication for preventing or treating seizures?  □ Yes\* □ No |
| **Vision Condition** | □ Yes □ No | If yes, and your child needs aids at school other than wearing glasses or contacts, please describe: |
| **Hearing Condition** | □ Yes □ No | If yes, and your child needs aids at school other than wearing a hearing aid, please describe:­­­­­­­­­­­­­­­­­­­  ­­­­­­­­­­­­­­­­­­­ |
| **Physical Limitations** | □ Yes □ No | Is your child able to participate in physical education class at school with no limitations? □ Yes □ No  If no, please list his/her activity limitations: |
| **Other Medication(s)** | □ Yes\* □ 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 and Evaluation Consent**

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| --- |
| In order to monitor the effectiveness of the program and ensure its future success, an independent evaluator is conducting an ongoing program evaluation. It is the intentions of the program evaluation to learn how these services help students and how the program can be improved in order to meet the grant requirements.  ***Individual student data will only be used to assess the 21st CCLC program and will not be made public.*** Participating in the evaluation will not affect my child in school, in the 21st CCLC program, or in any other way. My name or my child’s name will not be used in any report and our identities will not be recognizable in any report. At the end of the evaluation, all records that include personal information will be destroyed. Participation in this study is completely voluntary and is not required in the 21st CCLC program; participants may withdraw from the study at any time without affecting the child’s participation in the 21st CCLC program.  I consent to the program obtaining demographic data including but not limited to racial/ethnic group, gender, grade level, English proficiency, free or reduced-price lunch eligibility, and special needs from the [district/NYSED] for students in the 21st CCLC program. □ Yes □ No  I consent for the program to obtain my child’s records from [school/district/NYSED] showing his/her progress, information including but not limited to enrollment, grades, city and/or statewide test scores, and 21st CCLC program attendance. □ Yes □ No  I consent to for my child and I to participate in surveys and/or interviews about the 21st CCLC program and its effects. □ Yes □ No |

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