Sports & Arts in Schools Foundation – Engaging Students' Minds and Bodies

2014 Free Summer Program Registration Form March 23, 2014

Dear Parent / Guardian:

Welcome to the 2014 SASF Summer Program! This free summer program is made possible by funding from the NY State Ed. 21st Century, NY City Council and/or Department of Youth and Community Development (DYCD). We are pleased to announce our 19th year of programming featuring specialized instruction from leading coaches and artist, exciting field trips, and educational activities!

Most programs are open from July 1-Aug. 7, Monday-Thursday, for 3 or 4 hours per day. Registration is taken on a first come, first served basis, so be sure to turn in your completed registration form as soon as possible. A medical form signed and stamped by a doctor is required for children ages 6-13. The medical form must contain all the appropriate vaccinations and must have occurred after August 9, 2013. **We cannot accept your child until both registration and medical forms are 100% complete.**

Each program operates in a New York City Public School and is directed by a highly qualified and experienced Program Director, with a dedicated staff that includes a Director of Sports and a Director of Arts. Each program will have a group of trained counselors who will mentor and guide your child through the summer. For more information on our summer programs, including a current list of summer program sites, please visit our website at www.sasfny.org or call our Summer Camp Hotline at 347-417-8155.

Please be aware that this program is being funded by public dollars, some of which will not be secured until late June 2014. As with all public funded programs there is the possibility that Sports & Arts In Schools Foundation's funding could be cut or delayed. This could impair our agency's ability to open the summer program site at your school.

Please mail or fax forms to:

Mail:
Sports & Arts in Schools Foundation
Attn: Summer Program Director
58-12 Queens Boulevard, Suite 1
Woodside, NY 11377
Fax:
347-238-2362

We look forward to seeing you at our camp!

Kermit Patterson
Director, Summer Programs
347-417-8155

This camp is licensed by the New York City Department of Health and Mental Hygiene and is inspected twice yearly. The inspection reports are filed at the Bureau of Food Safety and Community Sanitation located at 253 Broadway 12th Floor, CN 59A New York, N.Y. 10007.

Sports & Arts in Schools Foundation
Participant Enrollment Form

For Office Use Only:
Enrolled in YS _____
Enrolled in OST _____

Site: _____

Participant Information

_____ _____ _____

Last Name First Name OSIS#

Gender: Male Female Birth Date (month/day/year) _____

Full Home Address _____

Address Apt.

_____

City State Zip Code

_____

Home Number Cellular Number Email Address

****

Ethnicity American Indian Asian (Non-Hispanic) Black (Non-Hispanic)
Hispanic/Latino Pacific Islander White (Non-Hispanic) Other_____

**********_

_____ _____ _____

Primary Language English Proficient Y/N Grade

_____ _____

School Attending Class

****

Parent/Guardian Information

Last Name _____ First Name _____

Home Phone Number _____ Cellular Number_____

Email _____

Last Name _____ First Name _____

Home Phone Number _____ Cellular Number_____

Email _____

Emergency Contact:

Last Name _____ First Name _____

Phone Number _____ Relationship_____

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NYC Department of Education
Carmen Fariña, Chancellor

NYC Department of Youth & Community Development

United Way

TASC The After-School Corporation

Pick-Up Permissions

I give permission for my child to walk home alone at dismissal _____

Signature of Parent/Guardian

My child may be picked up by the following person: _____

My child may NOT be picked up by: _____

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

In consideration of your accepting my child into this program, I the undersigned, intending to be legally bound, hereby for myself, my heirs, executors, and administrators, waive and release any and all rights and claims for damages, that I may have against the Sports & Arts in Schools Foundation, its consultants, contractors, and employees and all sponsors, and their representatives and successors and assigns for any and all injuries suffered by my child virtue of his or her participation in this program. I 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 participation of the child listed above in this program.

Applicant Signature_____ Date_____

Parent/Guardian Signature _____ Date_____

Intake Officer Signature _____ Date_____

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly Press Hard

STUDENT ID NUMBER OSIS

TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | **Sex** ☐ Female ☐ Male | **Date of Birth** *(Month/Day/Year)* __ __ / __ __ / __ __ __ __

Child's Address | **Hispanic/Latino?** ☐ Yes ☐ No | **Race** *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other _____

City/Borough | State | Zip Code | School/Center/Camp Name | District Number __ __ __ __ | **Phone Numbers** *Home* _____ *Cell* _____ *Work* _____

Health insurance (including Medicaid)? ☐ Yes ☐ No | ☐ **Parent/Guardian** ☐ **Foster Parent** Last Name | First Name

TO BE COMPLETED BY HEALTH CARE PROVIDER *If "yes" to any item, please explain (attach addendum, if needed)*

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF/Asthma Action Plan):* ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Inhaled corticosteriod ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ **Other** *(specify)* _____

Explain all checked items above or on addendum

Medications *(attach MAF if in-school medication needed)*

☐ None ☐ Yes *(list below)*

Dietary Restrictions

☐ None ☐ Yes *(list below)*

PHYSICAL EXAMINATION

Height _____ **cm** (__ __ %ile)

Weight _____ **kg** (__ __ %ile)

BMI _____ **kg/m²** (__ __ %ile)

Head Circumference *(age ≤2 yrs)* _____ **cm** (__ __ %ile)

Blood Pressure *(age ≥3 yrs)* _____ / _____

General Appearance:

NI	Abnl		NI	Abnl		NI	Abnl		NI	Abnl		NI	Abnl	
☐	☐	HEENT	☐	☐	Lymph nodes	☐	☐	Abdomen	☐	☐	Skin	☐	☐	Psychosocial Development
☐	☐	Dental	☐	☐	Lungs	☐	☐	Genitourinary	☐	☐	Neurological	☐	☐	Language
☐	☐	Neck	☐	☐	Cardiovascular	☐	☐	Extremities	☐	☐	Back/spine	☐	☐	Behavioral

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)* ☐ Within normal limits

If delay suspected, specify below

☐ Cognitive *(e.g., play skills)* _____

☐ Communication/Language _____

☐ Social/Emotional _____

☐ Adaptive/Self-Help _____

☐ Motor _____

SCREENING TESTS	*Date Done*	*Results*
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	__/__/__	_____ µg/dL
	__/__/__	_____ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	__/__/__	☐ At risk *(do BLL)* ☐ Not at risk
Hearing ☐ Pure tone audiometry ☐ OAE	__/__/__	☐ Normal ☐ Abnormal
Head Start Only		
Hemoglobin or Hematocrit *(age 9–12 mo)*	__/__/__	_____ g/dL _____ %

	Date Done	*Results*
Tuberculosis *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school*		
PPD/Mantoux *placed*	__/__/__	Induration _____mm
PPD/Mantoux *read*	__/__/__	☐ Neg ☐ Pos
Interferon Test	__/__/__	☐ Neg ☐ Pos
Chest x-ray *(if PPD or Interferon positive)*	__/__/__	☐ NI ☐ Abnl ☐ Not Indicated
Vision *(required for new school entrants and children age 4–7 yrs)*	__/__/__ ☐ with glasses	Acuity *Right* ___/___ *Left* ___/___ Strabismus ☐ No ☐ Yes

IMMUNIZATIONS – DATES CIR Number of Child

Hep B	__/__/__	__/__/__	__/__/__	__/__/__
Rotavirus	__/__/__	__/__/__	__/__/__	__/__/__
DTP/DTaP/DT	__/__/__	__/__/__	__/__/__	__/__/__
	__/__/__	__/__/__	__/__/__	__/__/__
Hib	__/__/__	__/__/__	__/__/__	__/__/__
PCV	__/__/__	__/__/__	__/__/__	__/__/__
Polio	__/__/__	__/__/__	__/__/__	__/__/__

Influenza	__/__/__	__/__/__	__/__/__	__/__/__
MMR	__/__/__	__/__/__	__/__/__	__/__/__
Varicella	__/__/__	__/__/__		
Td	__/__/__	__/__/__	__/__/__	__/__/__
Tdap __/__/__	Hep A	__/__/__	__/__/__	
Meningococcal	__/__/__	__/__/__		
HPV	__/__/__	__/__/__	__/__/__	
Other, *specify:* _____	__/__/__	; _____		__/__/__

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet

☐ Restrictions *(specify)* _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: __/__/__

Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision

☐ Other _____

ASSESSMENT ☐ **Well Child** (V20.2) ☐ **Diagnoses/Problems** *(list)* **ICD-9 Code**

_____ __ __ __ __

_____ __ __ __ __

_____ __ __ __ __

Health Care Provider Signature | Date __ __ / __ __ / __ __ __ __

Health Care Provider Name and Degree *(print)* | Provider License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (__ __ __) __ __ __ – __ __ __ __ | Fax (__ __ __) __ __ __ – __ __ __ __

DOHMH ONLY **PROVIDER I.D.**

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments

Date Reviewed: __/__/__ I.D. NUMBER

REVIEWER:

Copies: **White** School/Child Care/Early Intervention/Camp, **Canary** Health Care Provider, **Pink** Parent/Guardian

Sports & Arts in Schools Foundation
EMERGENCY MEDICAL CARE FORM

(To be completed by the parent or guardian)

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 summer 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.**

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

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

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

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

3. **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: _____

4. **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 summer program.**

_____

Parent/Guardian Signature **Date**

Sports & Arts in Schools Foundation

Parent Consent to Participate in the Evaluation of the Summer Program

Dear Parent/Guardian,

Your child, _____, is enrolled in the summer program at _____, which is supported by Sports and Arts in Schools Foundation and the Department of Youth and Community Development (DYCD), 21st CCLC, The After-School Corporation (TASC), the New York State Office of Children and Family Services, or the United Way. In order to monitor the effectiveness of the summer program and ensure its future success, these organizations along with Policy Studies Associates (PSA) and Youth Studies, Inc. (YSI) are conducting ongoing evaluations. It is the intention of the evaluations 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 such as report cards and transcripts including information about high school and college enrollment, 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. There will be up to four surveys over the course of the year. Each will take approximately 15 minutes. Group discussions may also be held, that would take up to 30 minutes.

Any information we collect will be used only to assess the summer program and will not be made public. Participating in the evaluation will not affect your child in school, in the summer program, or in any other way. Personal information will not be used for any purposes after the evaluation is complete. Participation in the study is completely voluntary and participants may withdraw at any time with no consequences. AIDP Participants must be willing to participate in the evaluation; otherwise, they may not participate in the AIDP program.

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 summer program. I also consent for the above organizations to obtain my child's records and to interview program and school staff for evaluation and support 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 summer program.*

_____

Signature Date

If you have any questions about the evaluation, please contact the program evaluator, who is either Anne Thompson, Youth Studies, Inc., or Bruce Kaufmann.
contact information of the evaluator for your child.

Sports & Arts in Schools Foundation

PHOTO/VIDEO/INTERVIEW CONSENT

(To be completed by the parent or guardian)

I certify that I am the parent or legal guardian of _____, whose date of birth is _____.
name of child
month/day/year

I understand that SASF holds events both in-school and away from school. Media representatives, newspaper and television reporters, photographers, and public-relations personnel may be present at these special events to record them. In some cases they may interview and/or photograph children who participate in these events, including my child. These photographs, videos, and interviews will only be used to promote SASF.

I am aware that my child may be asked a variety of questions concerning SASF and SASF related activities and programs, and that the contents of the interview may be published or aired publicly. I understand that my child will be under the supervision of SASF personnel during the interview or photo session. However, there may not be SASF personnel supervision if the photographs or video or voice recordings are part of a general background scene in which my child is not identified.

I understand that my child reserves the right to refuse to answer any questions or participate in any discussions that make him/her feel uncomfortable or embarrassed and that my child and/or the supervising SASF personnel may terminate the interview, photo or video session at any time for any reason.

I give permission for my child to be photographed or otherwise recorded during SASF events and activities, and for any and all such photographs and/or recordings to be displayed by the Sports and Arts in Schools Foundation Champions Club, The After-School Corporation, the United Way, the New York State Office of Children and Family Services, or The Department of Youth and Community Development in any medium (books, newsletters, web sites, etc.), whether now or hereafter known or developed, for which neither my child or I shall receive monetary compensation or ownership rights.

SIGNATURE OF PARENT OR GUARDIAN **DATE**

If you **do not** wish for your child to participate in the activities described above, please review this section of this form.

I **DO NOT** give permission for my child to be photographed or otherwise recorded during summer events and activities. As a result, my child may not be able to participate in these events and activities.

SIGNATURE OF PARENT OR GUARDIAN **DATE**

Parent/Guardian Data Release Consent Form

I. Information being requested.

SASF is requesting your permission to collect academic performance and enrollment data on your child. This information will be used for the purposes of establishing program outcomes and may be used in an aggregated format to help advocate for continued funding.

II. What information from your child's student records is SASF requesting?

We are requesting your permission to allow/authorize SASF to obtain personally identifiable information from your child's student records from **NYC Department of Education (DOE).** Simultaneously, you are authorizing the DOE to release personally identifiable information from your child's student records with SASF. The following 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 fitness gram 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.

III. How will your child's data remain confidential?

The only people authorized to view your child's information are the SASF Data Department and DOE staff who manage the data systems and prepare research reports and program analyses. A limited number of SASF staff identified to receive personal information is screened, provided extensive training 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 SASF and will be secured and protected in the SASF data base. We will not use your name or your child's name in any published report. While we request your consent, your responses to the requests below will not affect your child's participation in our programs.

Please check Yes or No to the following statement:

- I understand why SASF is asking my permission to access the information listed above from my child's student records, and I give permission to DOE to share that information with SASF on an ongoing basis.

___ **Yes, I authorize SASF and DOE to share my child's information/student records.**

___No, I do not authorize SASF and DOE to share my child's information/student records

Student/Applicant Name: _____

Parent/Guardian Name: *(Please Print)* _____

Parent/Guardian Signature: _____ Date: _____

Additional Parent/Guardian Name: *(optional)* _____

Additional Parent/Guardian Signature*: (optional)* _____