

For Office Use Only
Date Enrolled: _____



**YMCA of Paterson
Family Services Center**

STUDENT ENROLLMENT FORM - FY 15-16

Print Student Name: _____
First Last

Birth Date: _____
Month/Day/Year

Grade: _____ School Attending: _____

Gender: Male Female Race/Ethnicity _____ Unspecified

Special Needs: Yes No Unspecified

Limited English Proficiency: Yes No Unspecified

Free/Reduced Lunch: Yes No Unspecified

Please note you must complete the above fields for your child to be enrolled in the YMCA of Paterson After School Program.

PARENT/GUARDIAN INFORMATION

Parent/Guardian #1

Parent/Guardian # 2

First Name Last Name

First Name Last Name

Relationship to Student

Relationship to Student

Home Phone

Home Phone

Employer

Employer

Work Phone

Work Phone

Other Phone

Other Phone

E-mail

E-mail

Street Address

Street Address

City State Zip

City State Zip

RELEASE OF CHILD

My child will be picked up by the close of program by me or one of the following individuals:

Name Relationship to Child Telephone

Name Relationship to Child Telephone

***** **DO NOT RELEASE MY CHILD TO THE FOLLOWING PEOPLE*******

Name Relationship to Child

Name Relationship to Child

Is there a restraining order involving your child?

Yes (If yes, please speak with the Program Director) No Unspecified

If there is an IEP for the child or 504 accommodations plan?

Yes (If yes, please speak with the Program Director) No Unspecified

EMERGENCY CONTACTS

Please identify two persons who may be called between 3:00pm and 7:00pm if you are not available.

First Name Last Name

First Name Last Name

Relationship to Student

Relationship to Student

Home Phone

Home Phone

Cell Phone

Cell Phone

Work Phone

Work Phone

Other Phone

Other Phone

Street Address

Street Address

City State Zip

City State Zip

PARENT/GUARDIAN SIGNATURE

I give my child permission to participate in the afterschool program.

I allow the school to release to the YMCA of Paterson program, information about my child's school performance, including, but not limited to, IEP's, grades and test results. Yes No

Parent/Guardian Signature

Date

EMERGENCY MEDICAL CARE (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 after-school 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. This information is strictly confidential and will not be shared with anyone without my written consent or in the case of emergency medical care.**
- 3. Following emergency medical care, my child may be released to the following people:**

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

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

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

4. 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: _____

- 5. 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 after-school program.**

Parent/Guardian Signature

Date

STUDENT HEALTH RECORD (To be completed by the parent or guardian)

This confidential health record will only be used to ensure the safety of the children in this program. This information will not be shared outside of this afterschool program. Feel free to continue your notes on back of this form.

Student's Name:

Date of Birth:

1 . Please provide your child's medical history.

CONDITION	YES (if yes, write approx. date)	NO
Asthma	<input type="checkbox"/> _____	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/> _____	<input type="checkbox"/>
Diabetes	<input type="checkbox"/> _____	<input type="checkbox"/>
Ear Infections	<input type="checkbox"/> _____	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/> _____	<input type="checkbox"/>
Measles	<input type="checkbox"/> _____	<input type="checkbox"/>
German Measles	<input type="checkbox"/> _____	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/> _____	<input type="checkbox"/>
Mumps	<input type="checkbox"/> _____	<input type="checkbox"/>
Corrective Device (glasses, hearing aid, etc.)	<input type="checkbox"/> _____	<input type="checkbox"/>
Does your child use an inhaler?	<input type="checkbox"/> _____	<input type="checkbox"/>

ALLERGY	YES	NO
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Insect Stings	<input type="checkbox"/>	<input type="checkbox"/>
Foods	<input type="checkbox"/>	<input type="checkbox"/>
Plants	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Topical ointments	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
If "yes" to any of the above, please specify allergy and describe reaction.		

2 . List significant illnesses or surgeries. Provide the date and any instructions.

3 . Special situations or needs that program staff should be aware of:

<input type="checkbox"/> Child has behavioral/emotional difficulties
<input type="checkbox"/> Child has physical disabilities
<input type="checkbox"/> Other (describe)

4 . Special Health Care Needs

Does your child have special health care needs that require treatment and/or medication? YES NO

If yes, describe below. If your child requires treatment and/or medication during after-school hours, complete the *Health Care Plan for a Child with Special Health Care Needs* form.

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5 . Medication

Does your child take medication for any condition or illness? YES NO if yes, describe below.

If your child requires medication during after-school hours, complete the *Medication Consent* form.

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6 . Sunscreen and Topical Ointments

Do you give permission to the after-school program to apply sunscreen or other over-the-counter topical ointments on your child? YES NO

7 . Activities to be encouraged:

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8 . Activities your child cannot participate in:

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9 . My child may participate in all program activities, except those noted in number 8 above.

Parent/Guardian Signature

Date

*****PHOTO/VIDEO/INTERVIEW CONSENT*****

I certify that I am the parent or legal guardian of _____, whose date of birth is _____. I understand that this after-school program features special 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. These photographs, videos, and interviews will only be used to promote this after-school program.

I give permission for my child to be photographed or otherwise recorded during after-school events and activities, and for any and all such photographs to be displayed by [YMCA of Paterson] in any medium (books, newsletters, web sites, etc.), whether now or hereafter known or developed.

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 after-school 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

***** STUDENT'S PARTICPATION IN THE YMCA of Paterson EVALUATION STUDIES*****

YMCA of Paterson relies on evaluation to provide information about the quality of the services it provides and to identify the ways in which participants benefit from after-school activities. To allow the YMCA of Paterson and its authorized evaluators to continue this work, we ask your permission to:

- Communicate with you and/or your child about the program and its effects in an individual or group interview or a written survey
- Contact your child's school and obtain information from your child's teacher, including records from the district office, information about your child's academic progress, attendance, promotion between grade levels, and behavior
- Talk to teachers, school staff, and others about your child's progress, and review records on your child's participation in the YMCA of Paterson After School Program.

Any information collected about you or your child will be used only to assess the YMCA of Paterson program and will not be made public. Your name or your child's name will not appear in any report and, at the conclusion of all studies; records that include personal information will be destroyed.

Participating in evaluation studies YMCA of Paterson will not affect you or your child in school, in the YMCA of Paterson program, or in any other way. You can stop your child's participation in a study at any time. If you stop, it will not affect your child's enrollment in the YMCA of Paterson program. If you have any questions, please contact YMCA of Paterson at (973)684-2320 ext. 31 or 28.

The activities involved in participating in a study of YMCA of Paterson have been explained to me. I understand these activities, and (check one):

I give permission for my child, _____
to participate in studies of YMCA of Paterson. I also give my consent for YMCA of Paterson and firms authorized by YMCA of Paterson to obtain my child's records and to interview or survey program and school staff about my child for research purposes.

I do not give permission for my child, _____
to participate in any study of YMCA of Paterson.

SIGNATURE OF PARENT OR GUARDIAN DATE