



HeartShare
HUMAN SERVICES OF NEW YORK

NEW DYCD Application for 2018 Summer Camp

One World at P.S. 102

Enrollment Packet Overview

Please use this new version and answer all the questions below to help us provide quality services. If there is a question that you do not understand, please seek help.

This enrollment packet will allow you or your child to be enrolled in this program. The information captured through this form will help the program plan to provide a safe and healthy environment, and provide appropriate services. Enrollment packet sections:

- Applicant's Information
- Participant Background / Contact Information
- Participant Safety and Health
- Participant Pick-up
- Parent / Guardian Information
- Consent for Medical Emergency Treatment
- HeartShare Media Consent Form
- Sibling Inquiry Form
- T-Shirt Preference
- Physical Examination Form signed by the Physician (Page 7 of 7)

Please make sure you (Parent/Guardian) sign on pages 7,8,9 of 9/1,2,3,4, of 7.

Return your completed application either hard copy, fax or email to HeartShare at nada.arkadan@heartshare.org, or fax: 718-567-2367 no later than Wednesday, April 18, 2018.

Application Lottery will be on Friday, April 20, 2018 at 6pm in the auditorium.

Medical's must be submitted by June 15th, 2018 or participants will lose their spot for summer camp.

If you have any questions please contact Ms. Nada at 718-567-2365 by phone before April 18, 2018 or by email at any time.

**The HeartShare St. Vincent's Services at P.S 102 will be relocated-
Location is pending.**

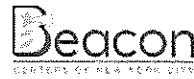
Office Use Only	
Date Application Received:	
Enrollment Start Date:	
Intake Specialist/Staff:	
Additional Information:	



DYCD Universal Participant Intake: Youth & Adult Application

Welcome to the Department of Youth and Community Development (DYCD)! DYCD is a New York City agency that funds programs for youth and families. These programs are operated by Community Based Organizations (CBOs). This form will allow you or your child to apply to a DYCD Comprehensive Afterschool System (COMPASS), Beacon, or Cornerstone youth or adult program. Please complete this form fully and return to the CBO that operates the program. One application will be accepted per person per site. **Submission of an application does not guarantee enrollment in the program.** Further paperwork and information may be required to determine program eligibility. If accepted, program will be **at no cost** to the participant. The following application items are collected for informational and program planning purposes only: *Income, Gender, Race, Ethnicity, Language, Population Type, Household Information and Health Insurance Status.* Responses to these questions will not impact your eligibility to receive services and will not be shared outside of DYCD without the applicant's permission.

Part I: Applicant Information		
<p>For the purposes of this application, applicant refers to the person applying to receive services. Select one:</p> <p><input type="checkbox"/> I am completing this application for <u>myself</u></p> <p><input type="checkbox"/> I am a parent or guardian completing this application <u>for my child</u></p> <p><input type="checkbox"/> I am a relative/non-relative, completing this application <u>on behalf of the applicant</u></p>		
Applicant's First Name:	Applicant's Last Name:	MI:
Applicant's Date of Birth (MM/DD/YEAR):		
<p>Applicant's Gender (Select One):</p> <p><input type="checkbox"/> Male</p> <p><input type="checkbox"/> Female</p> <p><input type="checkbox"/> Gender Nonconforming</p>	<p>Applicant's Race (Select all that Apply):</p> <p><input type="checkbox"/> American Indian and Alaskan Native</p> <p><input type="checkbox"/> Asian</p> <p><input type="checkbox"/> Black or African- American</p> <p><input type="checkbox"/> Native Hawaiian and Other Pacific Islander</p> <p><input type="checkbox"/> White or Caucasian</p> <p><input type="checkbox"/> Other</p>	<p>Applicant's Ethnicity (Select One):</p> <p><input type="checkbox"/> Hispanic or Latino(a)</p> <p><input type="checkbox"/> Not Hispanic or Latino(a)</p>
Applicant's Primary Address (Number and Street):		Apt. Number:
City:		Zip Code:
<input type="checkbox"/> Applicant lives in a NYCHA Development (please provide name) _____		



Part II: Contact Information				
Applicant's Contact Information				
<i>For youth without contact information, skip to the next section to provide parent/guardian contact information</i>				
Write down phone numbers for the <u>applicant</u> and circle the preferred method of contact:				
<input type="checkbox"/> Home _____	<input type="checkbox"/> Cell _____			
<input type="checkbox"/> Work _____	<input type="checkbox"/> Email _____	<input type="checkbox"/> No Email		
Parent/Guardian Information				
<i>This section is required for Applicants under 18</i>				
Parent/Guardian Name: _____				
Write down all phone numbers and circle the best number to call in case of an emergency:				
<input type="checkbox"/> Home _____	<input type="checkbox"/> Cell _____			
<input type="checkbox"/> Work _____	<input type="checkbox"/> Email _____	<input type="checkbox"/> No Email		
Address: <input type="checkbox"/> Same as Participant	City:	State:	Zip Code:	
Emergency Contact Information				
<i>At least one emergency contact must be identified</i>				
1	Emergency Contact #1 Name:		Relationship to Participant: <input type="checkbox"/> Emergency contact is parent/guardian of participant	
	Write down all phone numbers and circle the best number to call in case of an emergency:			
	<input type="checkbox"/> Home _____	<input type="checkbox"/> Cell _____		
	<input type="checkbox"/> Work _____	<input type="checkbox"/> Email _____	<input type="checkbox"/> No Email	
Address: <input type="checkbox"/> Same as Participant		City:	State:	Zip Code:
2	Emergency Contact #2 Name:		Relationship to Participant: <input type="checkbox"/> Emergency contact is parent/guardian of participant	
	Write down all phone numbers and circle the best number to call in case of an emergency:			
	<input type="checkbox"/> Home _____	<input type="checkbox"/> Cell _____		
	<input type="checkbox"/> Work _____	<input type="checkbox"/> Email _____	<input type="checkbox"/> No Email	
Address: <input type="checkbox"/> Same as Participant		City:	State:	Zip Code:



This section is for parents/guardians enrolling their children

Emergency contacts listed in Section II are authorized to pick up the child unless otherwise noted.

The following additional people are authorized to pick up my child:

Name: _____	Phone #: _____	Relationship: _____
Name: _____	Phone #: _____	Relationship: _____
Name: _____	Phone #: _____	Relationship: _____

The following people MAY NOT pick up my child:

Name: _____	Name: _____	Name: _____
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Part III: Applicant's Education/Work Status

Applicant's Education Status (Select One):

Full-Time Student***
 Part-Time Student***
 Not in School****

***If applicant is a *Part-Time Student* or *Full-Time Student*: **Select applicant's current grade (Select One):**

****If applicant is *Not in School*: **Select the last grade completed by the applicant (Select One):**

Elementary School: Pre-K K 1st 2nd 3rd 4th 5th

Middle School: 6th 7th 8th

High School: 9th 10th 11th 12th

Community College: 1st year 2nd Year 3rd year 4th Year 5th year 6th Year+

College/University: Freshman Sophomore Junior Senior

Other: High School Equivalence (HSE) Vocational/Trade School Foreign Degree

Applicant's Current Work Status (Select One):

Employed Full-Time Employed Part-Time Retired
 Unemployed (Short-Term, 6 months or less) Unemployed (Long-term, more than 6 months) Unemployed (Not in labor force)
 Migrant Seasonal Farm Worker Not applicable (applicant is under 14 years of age)

Required for Full-Time Students

Student ID/ OSIS:	School Type: <input type="checkbox"/> Public <input type="checkbox"/> Charter <input type="checkbox"/> Private <input type="checkbox"/> Other _____	
School Name:		
School Address:	City:	Zip Code:



Part IV: Health Information

Applicant's Health Information
*Please answer the questions below and provide additional details in the space provided.
 Many needs or health challenges can be accommodated and may not limit enrollment in the program.*

Does the applicant have any allergies? (food, medication, etc.)
 No Yes _____

Does the applicant have asthma?
 No Yes _____

Does the applicant have special health care needs?
 No Yes _____

Does the applicant take medication for any condition or illness?
 No Yes _____

Are there activities the applicant cannot participate in?
 No Yes _____

Please provide any additional health information details:

 N/A

Please list any accommodation(s) you are requesting for yourself/the applicant:

 N/A

Applicant's Health Insurance Status

<p>Does the applicant have health insurance? (Select One):</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to Answer</p>	<p>If yes, what kind of health insurance does the applicant have? (Check all that Apply):</p> <table border="0"> <tr> <td><input type="checkbox"/> Medicaid</td> <td><input type="checkbox"/> Medicare</td> <td><input type="checkbox"/> State Children's Health Insurance Program</td> </tr> <tr> <td><input type="checkbox"/> Employment-Based</td> <td><input type="checkbox"/> Direct-Purchase</td> <td><input type="checkbox"/> State Children's Health Insurance for Adults</td> </tr> <tr> <td><input type="checkbox"/> Military Health Care</td> <td><input type="checkbox"/> Decline to Answer</td> <td></td> </tr> </table>	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicare	<input type="checkbox"/> State Children's Health Insurance Program	<input type="checkbox"/> Employment-Based	<input type="checkbox"/> Direct-Purchase	<input type="checkbox"/> State Children's Health Insurance for Adults	<input type="checkbox"/> Military Health Care	<input type="checkbox"/> Decline to Answer	
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicare	<input type="checkbox"/> State Children's Health Insurance Program								
<input type="checkbox"/> Employment-Based	<input type="checkbox"/> Direct-Purchase	<input type="checkbox"/> State Children's Health Insurance for Adults								
<input type="checkbox"/> Military Health Care	<input type="checkbox"/> Decline to Answer									

If you do not have health insurance, do you want to be contacted by someone else with information about signing up for public health insurance? (Select One):

Yes No Decline to Answer

If you would like to be contacted about signing up for public health insurance, what is your preferred method of contact? (Select One):

Email Phone US Mail Via provider
 Decline to Answer

Part V: Additional Applicant Information

How well does the applicant speak English?
(Select One):

- Fluent/Very well
- Well
- Not well
- Not well at all

Applicant's Primary Language (Select One):

- | | | |
|---|--|-----------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Albanian | <input type="checkbox"/> Arabic |
| <input type="checkbox"/> Bengali | <input type="checkbox"/> Chinese* | <input type="checkbox"/> French |
| <input type="checkbox"/> Fulani | <input type="checkbox"/> German | <input type="checkbox"/> Gujarati |
| <input type="checkbox"/> Haitian Creole | <input type="checkbox"/> Hebrew | <input type="checkbox"/> Hindi |
| <input type="checkbox"/> Hungarian | <input type="checkbox"/> Italian | <input type="checkbox"/> Japanese |
| <input type="checkbox"/> Korean | <input type="checkbox"/> Kru, Ibo, or Yoruba | <input type="checkbox"/> Mande |
| <input type="checkbox"/> Punjabi | <input type="checkbox"/> Persian | <input type="checkbox"/> Polish |
| <input type="checkbox"/> Portuguese | <input type="checkbox"/> Romanian | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Spanish | <input type="checkbox"/> Tagalog | <input type="checkbox"/> Turkish |
| <input type="checkbox"/> Urdu | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Yiddish |

Other: _____

**including Cantonese and Mandarin*

Other Languages Spoken by Applicant (Select all that Apply):

- | | | |
|---|--|-----------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Albanian | <input type="checkbox"/> Arabic |
| <input type="checkbox"/> Bengali | <input type="checkbox"/> Chinese* | <input type="checkbox"/> French |
| <input type="checkbox"/> Fulani | <input type="checkbox"/> German | <input type="checkbox"/> Gujarati |
| <input type="checkbox"/> Haitian Creole | <input type="checkbox"/> Hebrew | <input type="checkbox"/> Hindi |
| <input type="checkbox"/> Hungarian | <input type="checkbox"/> Italian | <input type="checkbox"/> Japanese |
| <input type="checkbox"/> Korean | <input type="checkbox"/> Kru, Ibo, or Yoruba | <input type="checkbox"/> Mande |
| <input type="checkbox"/> Punjabi | <input type="checkbox"/> Persian | <input type="checkbox"/> Polish |
| <input type="checkbox"/> Portuguese | <input type="checkbox"/> Romanian | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Spanish | <input type="checkbox"/> Tagalog | <input type="checkbox"/> Turkish |
| <input type="checkbox"/> Urdu | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Yiddish |

Other: _____

Not applicable (only one language spoken by applicant)

**including Cantonese and Mandarin*

**Would the applicant like to receive information/
be contacted about registering to vote?***
(Select One):

- Yes No

**Applicant is eligible to vote in U.S. federal elections if:
1) You are a U.S. citizen;
2) You meet your state's residency requirements;
3) You are 18 years old. Some states allow 17-year-olds to vote in primaries and/or register to vote if they will be 18 before the general election. Check your state's voter registration age requirements.

Is the applicant any of the following:

- | | |
|----------------------------------|---|
| Parent/Legal Guardian? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Offender/Justice Involved? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Foster Care Participant? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Runaway Youth? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Veteran? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Active Military Personnel? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| An Individual with a Disability? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to answer |

If the applicant is an individual with a disability, please select disability type(s)
(Select all that Apply):

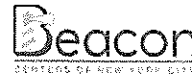
- Cognitive impairment
- Hearing-related
- Learning disability
- Mental or Psychiatric
- Physical/Chronic Health Condition
- Physical/Mobility Impairment
- Vision-related
- Other: _____
- Decline to Answer



Part VI: Household Information

For all the next set of questions, **HOUSEHOLD** is defined as any individual or group of individuals (family or non-family members) who are living together as one economic unit. **INCOME** is defined as the total annual gross income of all family and non-family members 18+years old living within the household.

The applicant lives in a household that is headed by (Select One):		Applicant's Housing Type (Select One):	
<input type="checkbox"/> Single Parent - Female <input type="checkbox"/> Single Parent - Male <input type="checkbox"/> Single Person - No children <input type="checkbox"/> Non-related adults with children	<input type="checkbox"/> Two Adults – No Children <input type="checkbox"/> Two Parent Household <input type="checkbox"/> Multigenerational Household <input type="checkbox"/> Other: _____	<input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> NYCHA <input type="checkbox"/> Shelter <input type="checkbox"/> Homeless <input type="checkbox"/> Other Permanent Housing <input type="checkbox"/> Other: _____	
Applicant's Household Size (Select One):		Total Household Income in the last 12 Months (Select One):	
<input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three <input type="checkbox"/> Four <input type="checkbox"/> Five <input type="checkbox"/> Six <input type="checkbox"/> Seven <input type="checkbox"/> Eight <input type="checkbox"/> Nine <input type="checkbox"/> Ten <input type="checkbox"/> Eleven <input type="checkbox"/> Twelve <input type="checkbox"/> Thirteen <input type="checkbox"/> Fourteen <input type="checkbox"/> Fifteen <input type="checkbox"/> Sixteen <input type="checkbox"/> Seventeen <input type="checkbox"/> Eighteen <input type="checkbox"/> Nineteen <input type="checkbox"/> Twenty+		<input type="checkbox"/> \$0 <input type="checkbox"/> \$1 to \$12,060 <input type="checkbox"/> \$12,061 to \$16,240 <input type="checkbox"/> \$16,241 to \$20,420 <input type="checkbox"/> \$20,421 to \$24,600 <input type="checkbox"/> \$24,601 to \$28,780 <input type="checkbox"/> \$28,781 to \$32,960 <input type="checkbox"/> \$32,961 to \$37,140 <input type="checkbox"/> \$37,141 to \$41,320 <input type="checkbox"/> \$41,321 to \$50,000 <input type="checkbox"/> \$50,001 to \$60,000 <input type="checkbox"/> \$60,001 to \$70,000 <input type="checkbox"/> \$70,001 to \$80,000 <input type="checkbox"/> \$80,001 to \$90,000 <input type="checkbox"/> \$90,001 to \$100,000 <input type="checkbox"/> \$100,000+ <input type="checkbox"/> Decline to Answer	
Sources of Applicant's Household Income (Select all that Apply):			
<input type="checkbox"/> Employment Wages <input type="checkbox"/> Affordable Care Act Subsidy <input type="checkbox"/> Alimony or other Spousal Support <input type="checkbox"/> Child Support <input type="checkbox"/> Childcare Voucher <input type="checkbox"/> Earned Income Tax Credit (EITC) <input type="checkbox"/> Employment Tax Credit <input type="checkbox"/> General Assistance <input type="checkbox"/> Housing Choice Voucher <input type="checkbox"/> HUD-VASH <input type="checkbox"/> LIEHEAP <input type="checkbox"/> Pension <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Private Disability Insurance <input type="checkbox"/> Public Housing <input type="checkbox"/> Safety Net/Home Relief <input type="checkbox"/> Retirement Income from Social Security <input type="checkbox"/> Social Security Disability Income (SSDI) <input type="checkbox"/> Supplemental Security Income (SSI) <input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP) <input type="checkbox"/> Temporary Assistance for Needy Families (TANF) <input type="checkbox"/> Unemployment Insurance <input type="checkbox"/> VA Non-Service Connected Disability Pension <input type="checkbox"/> VA Service-Connected Disability Compensation <input type="checkbox"/> WIC <input type="checkbox"/> Worker's Compensation <input type="checkbox"/> Other: _____			
<input type="checkbox"/> Decline to Answer			



Part VII: Consents and Signatures

Pick-up/Dismissal Information

This question must be answered for parents/guardians enrolling their children

My child has permission to travel home alone at dismissal:

Yes No

Consent to Participate

To the best of my knowledge the information above is true. I agree to its verification and understand that falsification may be grounds for termination of service. Information provided may be used by the City of New York to improve City services and access to those services, and to access additional funding.

If participant is 18 and over:

I acknowledge that I am 18 years of age or older and am authorized to give consent.

Yes No

Participant's Signature

Participant: Print Name

Date

If participant is under 18 years old:

Parent/Guardian's Signature

Parent/Guardian: Print Name

Date

Consent for Emergency Medical Treatment

If participant is 18 and over

I am enrolled as a participant in a DYCD-funded program. In the event of a medical emergency, I hereby give consent for necessary emergency medical treatment to be obtained on my behalf. I further authorize the emergency contact(s) listed to be contacted.

Yes, I give my permission No, I do not give permission

Participant's Signature

Participant: Print Name

Date

If participant is under 18 years old:

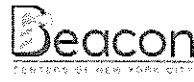
My child is enrolled as a participant in a DYCD-funded program. In the event of a medical emergency, I hereby give consent for necessary emergency medical treatment for my child to be obtained, with the understanding that I will be notified as soon as possible. I understand that every effort will be made to contact me, or, if I am unavailable, the emergency contact(s) listed, before and after medical care is provided.

Yes, I give my permission No, I do not give permission

Parent/Guardian's Signature

Parent/Guardian: Print Name

Date



Consent for Photography/Videotaping and Use of Original Work

As a participant enrolled in a DYCD-funded program, please be aware that from time to time DYCD and the City of New York, its contracted providers, authorized agents, third-party organizations with which it collaborates, or other government, representatives (collectively, "Authorized Parties") may be present during program activities and special events associated with program services, both at the usual program location and at off-site events. In some cases, they may photograph, videotape, interview or otherwise record participants and their families and friends in these programs. The resulting images, videos, and interviews may be used, with or without the participant's name, in printed and electronic media such as brochures, books, print and email newsletters, DVDs and videos, websites, social media and blogs (collectively, "Media").

I hereby authorize and permit the Authorized Parties, without compensation and without further approval, to photograph and/or record my and my child's image, name, likeness, and the sound of my and my child's voice during DYCD-funded program activities and special events, and I hereby consent to the resulting images, videos and interviews being used, without compensation and without further approval by the Authorized Parties solely for non-profit, non-commercial purposes in any and all Media.

Yes No

If, in the course of participating in DYCD-funded program activities and special events, any original work such as art, music, choreography, poetry, or prose (collectively, "Original Work") is created by me or my child, I hereby consent to such Original Work being used by the Authorized Parties, without compensation and without further approval, solely for non-profit, non-commercial purposes in any and all Media.

Yes No

If participant is 18 and over:

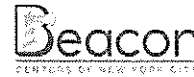
I acknowledge that I am 18 years of age or older and am authorized to give consent.

Yes No

Full Name of Participant Participant's Signature Date

If participant is under 18 years old:

Full Name of Participant Parent/Guardian's Signature Date



Parent/Guardian Consent to Collect and Share Student Information

The **Department of Youth and Community Development (DYCD)** provides funding for this program as part of its mission to help you assist your child reach his or her full potential. Many of our programs are run by community based organizations. We work to make sure the services you and your children receive are of the highest quality. DYCD is requesting your permission to allow us to collect information we need on your child, their participation and the quality of the services provided.

What information from your child's student records is DYCD requesting?

We are requesting your permission for the **NYC Department of Education (DOE)** to share personally identifiable information from your child's student records with DYCD. The 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 fitnessgram 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.

We are also requesting your permission for DYCD to share information we collect on the enrollment form from you and/or your child with DOE staff. The information includes registration information, student's interests and challenges, type of program enrolled-in and frequency of participation. This information will be used to help the school and community organization work together to meet you and your child's needs.

Who will see my child's information and how will it be safeguarded?

The only people who will see your child's individual information are DYCD and DOE staff who manage the data systems and prepare research reports and program analyses. The limited number of DYCD staff identified to receive personal information is screened, and 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 DYCD and will be secured and protected in the DYCD data base. Personally identifiable information will not be shared with any community based organizations or their staff members. We will not use your name or your child's name in any published report. While we request your consent, your responses to the below requests will not affect your child's participation in DYCD sponsored programs.

Please check Yes or No to each of the following statements:

I understand why DYCD 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 DYCD on an ongoing basis.

Yes, I give my permission **No, I do not give my permission**

I understand why DYCD is asking my permission to share information about my child collected by DYCD with DOE staff and I give my permission to DYCD to share information with DOE on an ongoing basis.

Yes, I give my permission **No, I do not give my permission**

Student/Applicant Name: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Additional Parent/Guardian Name (optional): _____

Additional Parent/Guardian Signature (optional): _____



CBO: _____

School: _____

Parent Consent for Participation in Afterschool Evaluation Data Collection (SONYC and COMPASS High Participants Only)

Dear Parent:

Your child is enrolled in an afterschool program that is supported by the Department of Youth and Community Development (DYCD). American Institutes for Research (AIR) is doing a study of the afterschool programs that are part of COMPASS. In order to monitor the effectiveness of these programs and ensure their future success, DYCD, and its evaluation partner AIR, are collecting information about participants and their experiences in the afterschool program, specifically around youth leadership development. This project has been approved by the Department of Education (DOE). AIR will visit some of the afterschool programs and survey its staff as well as youth and their families to learn more about DYCD afterschool programs and how they can be improved.

We ask permission from parents to conduct the following study activities:

- Administer 10-minute surveys to children asking about the DYCD afterschool program in which they participate and their perceptions of youth leadership development in the afterschool program
- Invite children to attend 45-minute focus group and/or interview about the DYCD afterschool program in which they participate, focused on their experience in the afterschool program and their perceptions of youth leadership development

AIR may also collect and analyze of your child's school records from New York City Department of Education, including demographic data, school day attendance, disciplinary referrals, grade promotion, and academic performance data (e.g., test scores and grades). These data are anonymous and completely confidential. The data will be combined to the school-level and we will not be able to link this school information to individual children or their families.

Any information we collect will be used only to assess the DYCD afterschool program and will not be made public. The only people who will have access to this information are members of the AIR evaluation team. Choosing not to participate in the evaluation will not affect your child in school, in the afterschool program, or in any other way. We will not use your name or your child's name in any report. There are no known risks to participating in this study. Participation is voluntary and participants may withdraw at any time. Please contact Jessica Newman by phone (312-588-7341) or email (jnewman@air.org) with questions about the study.

If you have concerns or questions about your child's rights as a participant, please contact AIR's Institutional Review Board (which is responsible for the protection of project participants) at IRB@air.org, toll free at 1-800-634-0797, or c/o IRB, 1000 Thomas Jefferson St. NW, Washington, DC 20007.

TURN THE PAGE TO COMPLETE AND SIGN →

Parent Consent for Participation in Afterschool Evaluation Data Collection

Please select from the options below:

- Yes, I GIVE PERMISSION FOR MY CHILD, _____, TO PARTICIPATE IN THE FOLLOWING AIR DATA COLLECTION ACTIVITIES:
- My child CAN complete AIR surveys about youth leadership development.
 - My child CAN attend focus groups and interviews about their experience in the afterschool program and their perceptions of youth leadership development.
 - Additionally, I would like to receive SMS text message updates about the evaluation of DYCD afterschool programs. AIR can send me text messages for future voluntary surveys. I understand that standard messaging may apply, and I can cancel at any time.
- No, I DO NOT WANT MY CHILD, _____, TO PARTICIPATE IN THE AIR DATA COLLECTION ACTIVITIES.

Signature

Date

Consent for Audio Recording

If you gave your child permission to participate in focus groups and interviews, AIR researchers may record the student focus group and interviews for note-taking purposes. If you allow AIR to record the focus group and interviews, please sign below. No one outside of the research team will hear the recording, and the recording will be deleted when the study is concluded. Students can request to have the recorder turned off at any point.

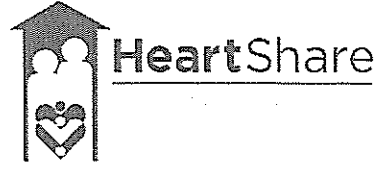
- Yes, I allow my child to be audio-recorded in the focus groups and interviews.
- No, I do not allow my child to be audio-record in the focus groups and interviews.

Signature

Date

If you have any questions or concerns about the evaluation, please contact Jessica Newman, the project manager at AIR, at (312) 588-7341 or by email at jnewman@air.org. If you have questions about DYCD afterschool programs, visit DYCD Youth Connect <http://www1.nyc.gov/site/dycd/connected/youth-connect.page> or call by phone at 1-800-246-4646.

COMPASS PROGRAM



Communications Department | 12 MetroTech Center, 29th Fl. | Brooklyn, NY 11201 | 718-422-3208 | www.heartshare.org

MEDIA CONSENT FORM FOR CHILDREN & YOUNG ADULTS

I, _____, am the parent/guardian of
_____ (referred to as “my child”), who resides at
_____, and participates in programs and activities
with HeartShare Human Services of New York and/or its affiliates, HeartShare Wellness, Ltd.,
The HeartShare School and HeartShare St. Vincent’s Services.

I hereby consent to my child’s participation in interviews, the use of quotes and the taking of photographs and/or videos of him/her on behalf of HeartShare Human Services of New York and its affiliates. I also grant the right to edit, use, and reuse said products for non-profit, non-commercial purposes, including in print, online, social media and all other forms of media. I consent to the use of my child’s name and association with HeartShare and its affiliates for the foregoing purposes. I give this authorization without expectations of compensation.

This consent will remain in effect until I revoke it in writing.

Signature: _____ Date: _____

HEALTH RECORD FOR CHILDREN IN DAY CAMPS & AFTERSCHOOL & YOUTH CENTERS
 (This side to be filled in by parent before presentation to physician)

NAME OF PROGRAM _____

CHILD'S LAST NAME _____ FIRST NAME _____ BIRTHDATE / / MO F SEX

Home Address: _____ Phone: _____

Parent or Guardian: _____ Phone: _____

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

Mother (Guardian) _____ Phone: _____

In case of emergency, notify: _____ Phone: _____

If Parent, Guardian are not available in an emergency, notify:

1. _____ Phone: _____

or 2. _____ Phone: _____

Important: Has this camper been exposed to any communicable disease during the three weeks prior to camp attendance:
 Yes No (If yes, state type of exposure: _____)

HEALTH HISTORY: (Check box if child has had afflictions, give appropriate dates)

- Rheumatic Fever _____
- Seizures _____
- Diabetes _____
- Asthma _____
- Chicken Pox _____

Allergies

- Hay Fever _____
- Poison Ivy, etc. _____
- Insect Stings _____
- Penicillin _____
- Other Drugs _____
- Food _____

Other Past Illnesses _____

Operations or Serious Injuries (Dates) _____

Hospitalization (Dates) _____

Chronic or Recurring Illness _____

Any specific activities to be encouraged? _____

Conditions that require activity to be restricted? _____

Permission for all program activities unless otherwise noted by Dr. _____

Appliance worn (glasses, contacts, etc.) _____

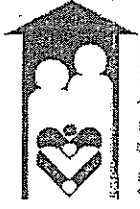
Medication taken _____

Suggestion from Parent/Guardian _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I do hereby give authority to the Day Camp and Year Round Afterschool and Youth Center Program staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Relationship _____ Signature _____ Date _____ Tel.# _____



HeartShare

**ST VINCENT'S
SERVICES**

Child's Name: _____

Current Grade: _____ Current Teacher: _____

GRADE IN SEPTEMBER: _____

Please list ALL siblings that you are enrolling in the after-school program (first and last name)

SIBLING _____ GRADE IN SEPTEMBER: _____

SIBLING _____ GRADE IN SEPTEMBER: _____

SIBLING _____ GRADE IN SEPTEMBER: _____

Summer Camp T-Shirt Size Preference

Please check off ONE t-shirt size for your child:

Child's First and Last Name: _____

Grade: _____

YOUTH SMALL _____

YOUTH MEDIUM _____

YOUTH LARGE _____

ADULT SMALL _____

ADULT MEDIUM _____

ADULT LARGE _____

ADULT X-LARGE _____



PHYSICAL EXAMINATION

(To be filled out by Physician - please note information on reverse side)

The purpose of this health record is to provide the staff with pertinent information which will help to serve the needs of this child in Day Camps and Afterschool and Youth Center programs.

IMMUNIZATION HISTORY - This is a record of dates of basic immunization and most recent booster doses.

DTP, DTP, DT, Td	Date _____	Date _____	Date _____	Date _____	Date _____
Polio	Date _____	Date _____	Date _____	Date _____	Date _____
MMR	Date _____	Date _____	Date _____		
Hemophilus Influenzae type b (Hib)		Date _____	Date _____	Date _____	Date _____
Hepatitis B	Date _____	Date _____	Date _____	Date _____	
Varicella	Date _____	Date _____			
Pneumococcal Conjugate (PCV)	Date _____	Date _____	Date _____	Date _____	Date _____
Other	Date _____	Other _____	Date _____	Other _____	Date _____

MEDICAL EXAMINATION - To be filled out by licensed physician.

Examination is acceptable when performed no more than 12 months prior to arrival at camp.

Code: S = Satisfactory
 X = Not Satisfactory (Explain)
 0 = Not Examined

General Appearance _____

Genitalia _____

Height _____ Weight _____ Blood Pressure _____ Posture & Spine _____ Throat - Tonsils _____

Nose _____ Teeth _____ Abdomen _____ Hernia _____ Feet _____ Lungs _____ Skin _____

Ig. Test (Date) _____ Urinalysis (Date) _____

Eyes _____ Vision _____ w/Glasses _____ Extremities _____ Heart _____

Ears _____ Hearing _____

Neurological Findings _____

Describe Abnormal Findings and/or Handicapping Conditions _____

Allergy: (Please specify) _____

Recommendations and restrictions while in camp:

Special Diet _____

Special Medicine (dose, route of administration, when should it be administered) _____

Is parent/guardian sending special medicine? _____

Activity Restrictions _____

Swimming _____ Diving _____

General Appraisal: _____

I have examined the person herein described, reviewed his/her health history and it is my opinion that he/she is physically able to engage in Day Camp/Year Round Afterschool and Youth Center activities, except as noted above.

 M.D.
 EXAMINING PHYSICIAN (SIGNATURE)

 PHYSICIAN'S NAME (PLEASE PRINT)

Telephone _____ Address _____

Date of Examination _____

