YouthCOR Summer Start-Up

Career Exposure Program

6th and 7th grade

Important concerns regarding (circle)	
Health	Developmental Abilities
Allergies	Release (custody)

Today's Date: _____

INFORMATION ABOUT STUDENT

Student's Name: _____

T-Shirt Size: ❑ Child ❑ Adult Small Medium Large XL (adult only)

Circle One

Date of Birth: ____/_____/_____

Student's Gender: ❑Male ❑Female Student I.D. Number_____

Home Address_____

City: Philadelphia Zip Code: _____ Phone: (____) _____

Email (to receive YouthCOR updates): _____

Student's School: _____ Current Grade: _____

Child's Race: ❑ Latino of any race
❑African-American/Black
❑ White/Caucasian
❑ American Indian/Alaskan Native
❑ Native Hawaiian/Pacific Islander
❑ Asian
❑Two or more races
❑ Other _____
❑ White

Language spoken at home: _____

Is child designated as ELL ❑ Yes ❑No

Program Site:

- ☐ Gilbert Spruance 21st CCLC
- ☐ Thurgood Marshall 21st CCLC
- ☐ Austin Meehan 21st CCLC
- ☐ St. Martin de Porres

☐ **Summer Start-Up**

July 6th – August 14th, 2020
8:30 AM – 3:00 PM
*due at time of enrollment
Applications due by 5/15/20

Program includes:

- breakfast, lunch, & snack
- career exposure activities,
- Start your own business $$
- clubs (art, dance, sports, etc.)
- college trips and field trips
- & more

Pennsylvania 21st Century Community Learning Centers
Soaring Beyond Expectations
Funded in full or in part with a grant by the Pennsylvania Department of Education

FAMILY INFORMATION

Mother's Name: _____ Cell Phone _____-_____-_____

Work Place _____ Work Phone _____-_____-_____

Work Address _____ City/Zip _____

Father's Name: _____ Cell Phone _____-_____-_____

Work Place _____ Work Phone _____-_____-_____

Work Address _____ City/Zip _____

In order for CORA to receive increased opportunities for funding, subsidies and materials please provide the following information:

Is Child a US Citizen? ❑Yes ❑ No Family size (including self and child)? _____

Is child/family receiving ❑TANF ❑ SSI ❑Food Stamps ❑ Medicaid Case # _____

Is child/family currently receiving services from DHS, including FES or Truancy Services? ❑Yes ❑ No

Family Income: (please check closest)

❑ less than $51,040 ❑$51,040 - $68,950 ❑ $68,960 - $86,870 ❑ $86,880 - $104,700

❑ $104,700 - $122, 710 ❑ $122,720 - $140,630 ❑ $140,630 - $158,550 ❑ More than $158,560

EMERGENCY INFORMATION/AUTHORIZATION FOR PICK UP

People, *other than parents*, to contact in case of emergency:

Name: _____Relation to Child: _____

Address: _____ City: _____

Home Phone: _____-_____-_____ Work/Cell Phone: _____-_____-_____

❑ Contact in case of emergency ❑ Person is authorized to pick up this child

Name: _____Relation to Child: _____

Address: _____ City: _____

Home Phone: _____-_____-_____ Work/Cell Phone: _____-_____-_____

❑ Contact in case of emergency ❑ Person is authorized to pick up this child

Name: _____Relation to Child: _____

Address: _____ City: _____

Home Phone: _____-_____-_____ Work/Cell Phone: _____-_____-_____

❑ Contact in case of emergency ❑ Person is authorized to pick up this child

Anyone specifically NOT allowed to pick up this child? (In case of divorce/separation, we will need a copy of divorce decree/custody court order)

Name: _____

Relation to Child: _____

IMPORTANT:

All children enrolled in YouthCOR must submit a record of a medical examination performed **within one year of the current enrollment date**, **including immunization record.**

Health Assessment form is included in application.

Health Information – Required by State Law

Child's physician of source of medical care:

Name: _____

Address: _____

Phone: _____-_____-_____

Health Insurance Coverage:

Insured: _____

Company: _____

Policy Number: _____

Please indicate any general health concerns (give details)

❑ Physical limitations/disabilities (description) _____

❑ Taking medication (description) _____

❑ History of convulsions (description) _____

❑ Asthma (description) _____

❑ Diabetes (description) _____

❑ Other _____

❑ **None of the Above**

Please indicate any **allergies** that your child has:

❑ Milk ❑ Stings/bites (which?) _____ ❑ Medications (list) _____

❑ Chocolate ❑ Foods (which?) _____ ❑ Other _____

❑ Juices (which?) _____ ❑ Animals (which?) _____ ❑ **No Known Allergies**

Additional information on any special needs? ❑No ❑Yes (Specify)_____

Medical or dietary information necessary in an emergency? _____

CONSENT AND RELEASE:

In consideration of the enrollment of my child, _____

(birth date _____/_____/_____) in CORA Services' Summer Camp 2020, I/we hereby consent to the following:

I. I give permission for my child to participate fully in all YouthCOR on-site program activities and special events without restriction, unless otherwise stated.

II. I agree that in case of accident or injury, emergency medical care may be given, a parent will be contacted as soon as possible, and the staff may act on my behalf.

III. I give consent for my child to receive minor first aid care from trained CORA YouthCOR staff. I also agree to pick up my sick child immediately.

IV. I consent for my child to take part in field trips or excursions involving those as listed in the YouthCOR calendar, or to take walks in the neighborhood under proper supervision, including possible trips to the local library or park. I understand that I will be asked to sign consent/permission forms for my child to participate in any off-site activities and to be transported in Agency or other approved vehicles.

V. If YouthCOR participates in water activities, I give consent for my child to swim and wade as part of these activities, understanding that all swimming activities will be under the supervision of a trained and certified lifeguard.

VI. I give consent for CORA Services to display in the news media, or electronically via the internet or in other displays, the artwork created by my child in connection with the YouthCOR. I also consent to have my child's artwork, including name, grade level and school displayed by CORA Services for the viewing of the general public.

VII. I grant CORA Services permission to display in the news media or electronically via the internet and in other displays, photographs and or video footage of my child taken in connection with his or her participation in the YouthCOR program.

VIII. I give consent for my child to participate in OST surveys, administered by both CORA Services and Public Health Management Corporation (PHMC) on behalf of the City of Philadelphia's Office of Children and Families' OST Project. (see parent packet for complete description)

IX. The information written on this form is accurate and true to the best of my knowledge, I understand that CORA Services staff will consult this form regarding important information about my child's health and safety. I further understand that I must update this form every 6 months (as required by law) or when information changes, whichever comes first.

SIX MONTH REAPPROVAL: I have reviewed this form and made all necessary updates.
(do not sign at time of enrollment)

_____

Thank you for completing this form in its entirety; specific information is required by Pennsylvania State regulations.

OFFICE USE

Date of Child's Admission: _____ Director's Initials:_____

CONSENT TO WALK HOME

May your child be released to walk home?

- ❑ **Yes, I would like my child to be released to walk home** and give consent for my child to be released by YouthCOR at 3:00 PM I grant my permission effective until further written notification is given by me. I release CORA Services from any liability for my child, once s/he leaves the program.
- ❑ **No, I do not authorize my child to be released to walk home.**

_____ _____

Signature of Parent or Guardian Date

DEVELOPMENTAL AND BEHAVIORAL ASSESSMENT

Does your child have an IEP? ❑Yes ❑ No

Does your child receive supplemental support services? ❑Yes ❑ No

If yes, please indicate in which areas he/she receives supplemental services:

❑ Academic/Learning ❑ Social/Emotional ❑ Speech/Language ❑ Health/Physical

Consent to Release Education Records under FERPA

I am the parent or guardian of the student listed on the application. As authorized by applicable law, including but not limited to the Family Education Rights and Privacy Act, 20 U.S.C., 1232g, and 34 C.F.R. Part 99 ("FERPA"), I consent and authorize The School District of Philadelphia (the "School District") to release education records concerning the Student, including confidential records of the School District to the City's Department of Human Services, the Public Health Management Corporation, and CORA Services YouthCOR program ("Recipients")

The School District releases these education records in connection with the Student's participation in YouthCOR program. The School District may disclose these education records only to the Recipients, and the Recipients may share this information only with other named Recipients, and with the Recipients' officers, staff, administrators and independent contractors under the Recipients' control. The Recipients may use these education records to research, study or evaluate OST programs.

If I ask, the School District will provide me with a copy of the records disclosed.

FERPA and other applicable laws protect the confidentiality of and your right to privacy concerning the Student's education records. The Recipients shall keep all information concerning the Student confidential and private to the fullest extent provided by applicable laws, including FERPA. Neither The School District nor the Recipients require me to waive any rights under these laws, and I give my consent voluntarily.

_____ _____

Parent/Guardian Signature Date

GETTING TO KNOW YOU - ADDITIONAL INFORMATION:

Is there anything you would like to share about your child with the staff? (personality, strengths, fears, etc.)

_____

_____

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG) ☐ YES ☐ NO	**NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.**	
	VISION (subjective until age 3)	
	HEARING (subjective until age 4)	
	LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:		TITLE:
	PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.