LACASA Afterschool Program
Sponsored by Strycker's Bay Neighborhood Council
105 West 86th Street #323 • New York NY 10025 212-874-3098
www.lacasakids.org

Please Indicate Use:
☐*Afterschool* ☐*Day Camp*

STUDENT ENROLLMENT FORM

This form must be completed and signed by the parent or guardian of a student enrolling in the after-school program.
Only Completed Forms will be Processed

STUDENT INFORMATION

TODAY'S DATE: aaaaaaaaaaaaaaaaaaa

Student Name ____________________ Home Phone aaaa____________________

Home Address ____________________ Apt. # Zip Code ____________________

City: o Bronx o Brooklyn o Manhattan o Queens o Staten Island

Birth Date ______aa_____a_____ (Mo. Day Year) Sex o M o F Race/Ethnicity (optional) ____________________

____________________ School Your Child Attends ______ Grade ____________________ Homeroom Teacher

Does your child receive free or reduced price lunch? o Yes o No

Will you be enrolling other children into the program? o Yes o No If *yes*, please complete the following:

____________________ Student Name ______ Grade ____________________ Homeroom Teacher

____________________ Student Name ______ Grade ____________________ Homeroom Teacher

PARENT/GUARDIAN INFORMATION

Parent/Guardian #1

Name ____________________ Relationship to student ____________________

Live in same home? o *Yes* o *No* If *no*, please complete the following: Home Phone ""____________________

Home Address ____________________ Apt. # Zip Code ____________________

City: o Bronx o Brooklyn o Manhattan o Queens o Staten Island Email ____________________

Work Phone ______a____________________ Speaks English? o Yes o No

Cell Phone ____________________ If *no* , specify____________________

Parent/Guardian #2

Name ____________________ Relationship to student ____________________

Live in same home? o *Yes* o *No* If *no*, please complete the following: Home Phone ____________________

Home Address ____________________ Zip Code ____________________

City: o Bronx o Brooklyn o Manhattan o Queens o Staten Island Email ____________________

Work Phone""""____________________ Speaks English? o Yes o No

Cell Phone ____________________ If *no* , specify____________________

RELEASE OF CHILD

A. I give my child permission to walk home alone at dismissal. o Yes o No

B. Does your child receive bussing? o Yes o No

C. My child will be picked up after-school by me or one of the following individuals:

Name_______________________________________ Relationship to student ______________

Home Phone"""________________________ Speaks English? o Yes o No

Cell Phone ________________________ If not, specify____________________

If the parent is unavailable, this person may be contacted in case of an emergency o Yes o No

Name_______________________________________ Relationship to student ______________

Home Phone"""________________________ Speaks English? o Yes o No

Cell Phone ________________________ If not, specify____________________

If the parent is unavailable, this person may be contacted in case of an emergency o Yes o No

Name_______________________________________ Relationship to student ______________

Home Phone"""________________________ Speaks English? o Yes o No

Cell Phone ________________________ If not, specify____________________

If the parent is unavailable, this person may be contacted in case of an emergency o Yes o No

_____ ***Yes, I have informed the persons above that they are listed as emergency contacts for my child***

C. DO NOT RELEASE MY CHILD TO THE FOLLOWING PEOPLE:

Name_______________________________________ Relationship to student ______________

Name_______________________________________ Relationship to student ______________

PARENT/GUARDIAN SIGNATURE

I give my child permission to participate in all program activities, including academic support, enrichment, social development, arts, sports, recreation, fitness and wellness. I understand that all program activities will be supervised by the community-based-organization providing the services. I agree that the professional staff of the after-school program may meet with my child and review my child's attendance, achievement and guidance records (for Attendance Improvement Dropout Prevention programs only) when appropriate. Our Summer Camp and After School programs are licensed by the NYC Department of Health and Mental Hygiene and are inspected twice yearly. The inspection reports are filed at the Bureau of Food Safety and Community Sanitation located at 253 Broadway, CN 59A New York, N.Y. 10007.

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Parent/Guardian Signature Date

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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. Feel free to continue your notes on back of this form

Student's Name ____________________________ Birth Date ______ ______ ______
Mo. Day Year

PLEASE PROVIDE YOUR CHILD'S MEDICAL HISTORY

Allergies to food	o Yes	o No	Specify____________________		
Behavioral/emotional issues	o Yes	o No	Specify____________________		
Individualized Education Plan	o Yes	o No	Specify____________________		
Physical Disabilities	o Yes	o No	Specify____________________		
Corrective Device	o Yes	o No	Specify (glasses, hearing aid, etc.)____________		
Asthma	o Yes	o No	Does your child use an inhaler?	o Yes	o No
Allergies to penicillin	o Yes	o No	Allergy to plants	o Yes	o No
Convulsions/seizures	o Yes	o No	Diabetes	o Yes	o No
Hay Fever	o Yes	o No	Allergy to insect stings	o Yes	o No

Other____

SPECIAL HEALTH CARE NEEDS o Yes o No
Does your child have special health care needs that require treatment and/or medication? 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.

MEDICATION o Yes o No
Does your child take medication for any condition or illness? If yes, describe below.
If your child requires medication during after-school hours, complete the *Medication Consent* form.

ACTIVITY PARTICIPATION o Yes o No
Are there any activities your child cannot participate in? If yes, describe below.

SUNSCREEN AND TOPICAL OINTMENTS o Yes o No
Do you give permission to the after-school program to apply sunscreen or other over-the-counter topical ointments on your child?

HEALTH/INSURANCE INFORMATION

Student's Doctor: ______________________________ Phone: ____________________

Insurance company: ______________________________ Policy Holder's ID:____________________

If my child requires emergency medical care and I cannot be reached, I give my consent to the above after-school or ELT/NYC 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. 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.

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Parent/Guardian Signature Date

THE NEW YORK CITY DEPARTMENT OF EDUCATION
JOEL I. KLEIN, *Chancellor*

Office of Communications & Media Relations
52 Chambers Street, New York, NY 10007
Tel.: 212-374-5141 Fax: 212-374-5584

CONSENT TO PHOTOGRAPH, FILM OR VIDEOTAPE A STUDENT FOR NON-PROFIT USE
(e.g.: educational, public service or health awareness purposes)

Name of Student: ____

School: ______________________________ Class: __________

I, ______________________________, hereby consent to the participation (Parent or Guardian's Name) in interviews, the use of quotes, and the taking of photographs, movies or video tapes of my son/daughter and his/her school-related work by LACASA After-School. I also grant to THE AFTER-SCHOOL CORPORATION the right to edit, use and reuse said products for non-profit purposes. I also hereby release the New York City Department of Education and its agents and employees from all claims, demands, and liabilities whatsoever in connection with the above.

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Signature of Parent/Guardian Date

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Address of Parent/Guardian

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