



WELCOME!

ENROLLMENT PACKET OVERVIEW

Please answer **all** of the questions below to help us provide quality services. Those marked with an asterisk (*) are optional. If there is a question that you do not understand, please seek help. You can speak with a worker at Strycker’s Bay Neighborhood Council via phone (212-874-7272) or email (info@stryckersbay.org).

This enrollment packet will allow 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:

- Welcome and Packet Overview (this page)
- Participant Background (pages 2, 3)
- Participant Health and Safety (pages 3, 4)
- Signatures (pages 5, 6)
- Parent Consent Form
- Other _____

PROGRAM OVERVIEW

LACASA (the Learning Action Center for Academic Success) After School Program *operates in the Upper West Side of Manhattan out of P.S.84 Lillian Weber School of the Arts. We provide a safe, nurturing environment where caring, passionate staff work to stimulate personal and academic growth in every child. Our goal is to provide equal access and opportunities for all school age youth with the tools and resources they need to become productive, responsible, and caring adults.*

This program is operated by:

Strycker’s Bay Neighborhood Council, Inc.
SITE ADDRESS: 32 W. 92nd Street, New York, NY 10025
SITE TELEPHONE #: 212-595-3481
MAILING ADDRESS: 105 W. 86th Street, #323, New York, NY 10024
MAIN OFFICE #: 212-874-7272
FAX #: 917-591-4995

This program is registered with the New York State Office of Children and Family Services School Age Child Care Program
SACC License #: 260231

Please save this page for your records and future reference.

1 PARTICIPANT BACKGROUND

Primary Parent / Guardian of Participant:	Who is enrolling in this program? <input type="checkbox"/> Me <input type="checkbox"/> My child <i>To register yourself, you must be 18+ years old.</i>
Phone number:	Phone number (2):
	Email Address:

participant contact information	Date	Program Year	
	Last Name	First Name	
	Home Address	Apartment Number	
	City	State	
	Zip Code	Borough	
	Home Phone	Cell Phone	
	Email	*SSN	
demographics	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> No Response	*Proof of ID <input type="checkbox"/> Birth Certificate <input type="checkbox"/> Passport <input type="checkbox"/> Driver's License <input type="checkbox"/> Non-Driver State ID <input type="checkbox"/> Other	
	Date of Birth		
	Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> No Response		
	Race <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> No Response		
student or employment status	Country of Origin	Primary Language	
	English Proficient <input type="checkbox"/> Yes <input type="checkbox"/> No	Additional Language(s)	
	Student Status Is the participant a student: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	
	School Type <input type="checkbox"/> Public <input type="checkbox"/> Charter <input type="checkbox"/> Private <input type="checkbox"/> Other	Student ID / OSIS #	
	School Name	School Address	
	Teacher/Advisor	Current Grade Level	
	If you are NOT a student, please provide the last school grade level completed:	<input type="checkbox"/> Grade K-11; please list your last grade: _____ <input type="checkbox"/> HS Graduate <input type="checkbox"/> HS Equivalency <input type="checkbox"/> Some College <input type="checkbox"/> College Degree	
	If you are NOT a student, are you:	<input type="checkbox"/> Unemployed for ____ weeks <input type="checkbox"/> Employed Full-time <input type="checkbox"/> Employed Part-time	
	other	Please list anyone else in your household who is participating in this program. Provide first and last names.	

1 PARTICIPANT BACKGROUND

Section 1. Participant Background (continued)

other family and household information	The participant lives in housing that is: <i>(Check all that apply)</i> <input type="checkbox"/> Rental <input type="checkbox"/> Family Owned <input type="checkbox"/> NYCHA housing		
	OR The participant is: <input type="checkbox"/> Homeless <input type="checkbox"/> Other:		
	Is or has the participant ever been in foster care:		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Has the participant been enrolled in programs operated by the Administration for Children's Services (ACS)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Is the participant or any member of the household (0-64 years old) covered by Medicaid, Child Health Plus, Family Health Plus, or private health insurance?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If you answered no to the previous question, would you like to be contacted by someone for assistance with health insurance?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Number of individuals in your household:		
	* Is the participant or any member of your household receiving public assistance?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	* Is the participant or any member of your household receiving food stamps?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	* Gross Yearly Household Income:		\$ _____
The participant lives in a household that is headed by:		<input type="checkbox"/> Self, Single, no children <input type="checkbox"/> Single Female Parent <input type="checkbox"/> Single Male Parent <input type="checkbox"/> Two Parents <input type="checkbox"/> Two Adults, no children	
* Sources of household income:			
<input type="checkbox"/> Employment		<input type="checkbox"/> TANF	
<input type="checkbox"/> Pension		<input type="checkbox"/> Social Security	
		<input type="checkbox"/> Unemployment Insurance	
		<input type="checkbox"/> General Assistance	
		<input type="checkbox"/> Other _____	

2 PARTICIPANT SAFETY

EMERGENCY CONTACTS. If there is an emergency, please contact the following individuals:

NAME	Relationship to Participant:	
Pick Up	<input type="checkbox"/> This person may pick up my child.	Contact	Write down all numbers and circle the best number to call in case of an emergency:
Address		<input type="checkbox"/> Home _____
Apartment		<input type="checkbox"/> Cell _____
City, State		<input type="checkbox"/> Work _____
Zip Code		<input type="checkbox"/> Email _____

NAME	Relationship to Participant:	
Pick Up	<input type="checkbox"/> This person may pick up my child.	Contact	Write down all numbers and circle the best number to call in case of an emergency:
Address		<input type="checkbox"/> Home _____
Apartment		<input type="checkbox"/> Cell _____
City, State		<input type="checkbox"/> Work _____
Zip Code		<input type="checkbox"/> Email _____

2 PARTICIPANT SAFETY

Section 2. Participant Safety (continued)

PARTICIPANT HEALTH INFORMATION.

Please check any of the following that pertain to the participant. Many needs or health challenges can be accommodated and may not limit enrollment in the program.

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Allergies to food | <input type="checkbox"/> Behavioral/Emotional Issues | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Allergies to medications | <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Medication | <input type="checkbox"/> Physical Disabilities |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Congestive Illness (e.g., heart murmur/disease, blood pressure) | <input type="checkbox"/> Corrective Devices (e.g., crutches, hearing aid, eye glasses) | <input type="checkbox"/> Pregnancy |

If you have checked any of the above OR there are other important health needs that may affect participation in the program, including activities that the participant MAY NOT do, please provide details:

 This section is only for parents enrolling their children. 

PICK UP/DISMISSAL INFORMATION.

My child has permission to walk home alone at dismissal. Yes No

My child MAY NOT be picked up by: _____

The following individuals are authorized to pick up my child:

NAME	Relationship to Participant
Write down all phone numbers and circle the best number to call in case of an emergency:	
Phone	<input type="checkbox"/> Home _____ <input type="checkbox"/> Cell _____
	<input type="checkbox"/> Work _____ <input type="checkbox"/> Other _____
Email Address:	

NAME	Relationship to Participant
Write down all phone numbers and circle the best number to call in case of an emergency:	
Phone	<input type="checkbox"/> Home _____ <input type="checkbox"/> Cell _____
	<input type="checkbox"/> Work _____ <input type="checkbox"/> Other _____
Email Address:	

Parent/Guardian Consent

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.

Consent to Collect and Share Student Information

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 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.

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 need.

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, 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: _____

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

Consent for Photo/Videotaping and Use of Youth Work

Please be aware that sometimes, staff, photographers, newspapers, television reporters, media representatives and public relations personnel may be present during program activities and special events, both in-school and away from school. In some cases, they may photograph, interview or otherwise record children who participate in these events. The resulting images, videos and interviews may be used solely for non-profit, non-commercial purposes of the program to promote the programs in printed and electronic media published by our agency, such as brochures, books, print and email newsletter, DVDs and videos, websites and blogs. These images may also be used by DYCD in its publications for non-profit educational purposes.

- I understand my child may be photographed, interviewed or otherwise recorded during program activities and special events and give permission for my child to be photographed, interviewed or otherwise recorded solely for non-profit, non-commercial purposes of the program.
 Yes, I give my permission No, you do not have permission
- I understand that my child’s work may be used in materials that promote programs, solely for non-profit, non-commercial purposes of the program.
 Yes, I give my permission No, you do not have permission

Consent for Emergency Medical Treatment

I give authority to the Program Agency’s staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible. I understand that every effort will be made to contact me before and after medical care is provided.

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

Consent Statement

I the undersigned, certify that I have reviewed all the above consent statements and indicated my wishes. I understand that consent is voluntary and I can withdraw it in writing at any time.

Student/Applicant Name

Student Signature (*if 18 or older*)

Parent/Guardian Name

Parent/Guardian Signature Date

Additional Parent/Guardian Name (*optional*)

Additional Parent/Guardian Signature Date

