After School Registration and Agreement Form

4400 N. Marshall Street
Philadelphia, PA 19140
215-329-5777
www.ayudacc.org

SCHOOL YEAR: 20_____
PROGRAM: (CHECK ONE) SOS (K-5TH) ☐ LOL (6TH-8TH) ☐

Date of Child's Admission_____
Date of Child's Withdrawal_____

Child's Name_____ Child's Nickname_____

Name of Parent _____

Home Phone #:_____ Cell#: _____ Email: _____

Address _____Zip Code_____
Adult(s) to whom child can be released to other than parent: _____Phone#:_____

Child's Birth Date___/____/____ Age_____ Gender: F ☐ M☐ **Soc.Sec.#_____**

Grade in September 20__: _____ Name of school _____ School I.D.#_____

Do you or your child receive any prevention or other services from the Department of Human Services (DHS)? Yes ☐ No ☐

Child's Arrival Time:_____ Child's Departure Time: _____

Late Fee: $10.00 for every 15 minutes after Child's Designated Departure Time

I, [print name]_____, give my child, _____, permission to participate in Ayuda Community Center's 20___ to 20___ School Year's **Support Our Students** (**SOS**-Elementary) After School Program OR **Living Our Lives** (**LOL** – Jr High) After School Program. I understand that he/she will be engaged in the following services:

Services to be provided as part of the after school's tuition —academic enrichment activities (literacy, math, science, social studies), homework help, playing games, extracurricular activities (sports related) , Structured Activities, field trips, arts and crafts, 2 Art Courses offered through Orange Korner Arts Program (OKA) for LOL Students, and learning more about the Bible.

Extra services to be provided at an additional fee if applicable: some field trips

- I relieve Ayuda Community Center and anyone connected with it from all financial liability for my child during the program and on all the trips outside our facility.
- I agree to pay for the above services according to the After School Tuition and Payment Schedules listed on the next page. Enclosed is my non-refundable **deposit of $50** to hold my registration choices. **All balances are due according to the payment schedule listed on the next page. All former balances from previous program years are to be made in full before registering for current program year.**
- Also included are the completed Ayuda After School Emergency Contact / Policies Signature Form, the Civil Rights Compliance Form, and Child Health Report.
- **All forms must be completed and submitted BEFORE the start of the school year in order for the child to be enrolled in the program**.

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Please do not write in this section.

Fee due for 1st child _____
Fee due for 2nd child _____
Fee due for 3rd child _____
Fee due for 4th child _____

Total Tuition Due: $ _____

Registration Fee ($50) Paid $_____ Date: __/__/__

Applying for CCIS?: Yes ☐ No☐

All Former Balances/Dues from previous program years are TO BE MADE IN FULL before registration

Payment Option 1: Full Payment

Total Tuition Due $_____ Paid $_____ Date __/__/___

Payment Option 2: Monthly Installments

Monthly Rate for 9 months: $_____

Monthly rate must be paid by the 5th of every month for 9 months.

If monthly rate is different each month, please indicate amounts below.

Sept 15th $_____	Dec 15th $_____	March 15th $_____
Oct 15th $_____	Jan 15th $_____	April 15th $_____
Nov 15th $_____	Feb 15th $_____	May 15th $_____

Picture/Art Release Form

I give permission for Ayuda Community Center Staff to take photos of my child for use in the displays and program (bulletin boards, wall décor, memory books, gifts, etc.) for After School or Summer Camp Program. Yes _____ and No _____

I give permission for Ayuda Community Center to use my child's photo on the website, and for promotional and/or training materials. (Personal information will NOT be included.) Yes _____ and No _____

_____

Child's Name Signature of Parent/Guardian Date

In case of emergency, the Director will replace the staff person accompanying the child. In case of accident or sudden illness, I/We authorize Ayuda staff to use the medical services of the nearest hospital. I/We consent to administration of medical care in the child's best interest.

_____

Signature of Parent/Guardian authorizing above **Date**

First aid: Parental consent is given to Ayuda staff to administer minor First-Aid procedures in the child's best interest.

_____

Signature of Parent/Guardian **Date**

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PLEASE CHECK IF YOU AGREE

☐ **I certify that all information in the Emergency Contact / Parental Consent Form is correct and updated.**

I certify that only the following are Persons Designated by Parent to whom Child may be released.

☐ **Only Those Listed on the Emergency Contact Form.**

☐ **Other**_____

☐ **I agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minimum (§3270.124, 3280.124, 3290.124)**

☐ **I have received complete written program information at the time of enrollment (§3270.121, 3280.121, 3290.121) and have read the enclosed Ayuda Summer Camp Parent Handbook and I agree to comply with the policies and procedures within it.**

Child's Name | Signature of Parent/Guardian | Date

PERIODIC REVIEW

Child's Name | Signature of Parent/Guardian | Date

PLEASE RETURN EMERGENCY CONTACT/PARENTAL CONSENT FORM WITH YOUR After School REGISTRATION FORM.

Ayuda recognizes the great responsibility of caring for your children. We endeavor to give you the most dependable and trustworthy professional services possible. In so doing, we have strict policies for our staff regarding observing and interacting with the children. If, for any reason, you think your child has been mistreated by another child or by a member of our staff, please call us. Please call us anytime: TheSite Supervisor, Pamela Ramos can be reached at 215-329-5777 or pramos@ayudacc.org, or the Executive Director , Cynthia Wright-Whitley can be reached at 215-329-5777 or cwright-whitley@ayudacc.org. We are here to serve you.

I have read the enclosed Ayuda After School Parent Handbook and I/we agree to comply with the policies and procedures within it.

The signature below confirms your Registration and Agreement for After School provisions stated above. Please note amounts due and credited tuition.

Parent/Guardian Signature: _____ Date: _____

Ayuda Staff Signature: _____Date:_____

Thank you for choosing Ayuda for your child's after school program.

EMERGENCY CONTACT / PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124(a)(b), 3270.181 & 182; 3280.124 (a)(b), 3280.181 & .182; 3290.124 (a)(b), 3290.181 & .182

CHILD'S NAME	BIRTHDATE
ADDRESS	

MOTHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	

FATHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	

EMERGENCY CONTACT PERSON(S)	NAME	TELEPHONE NUMBER WHEN CHILD IS IN CARE

PERSON(S) TO WHOM CHILD MAY BE RELEASED	NAME	ADDRESS	TELEPHONE NUMBER WHEN CHILD IS IN CARE

NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER	TELEPHONE NUMBER
ADDRESS	

SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTION)
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICATION, SPECIAL CONDITIONS
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD	
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS	POLICY NUMBER (REQUIRED)

PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT

OBTAINING EMERGENCY MEDICAL CARE	ADMIN. OF MINOR FIRST - AID PROCEDURES
WALKS AND TRIPS	SWIMMING
TRANSPORTATION BY THE FACILITY	WADING

PERIODIC REVIEW

SIGNATURE OF PARENT or GUARDIAN _____ DATE _____

SIGNATURE OF PARENT or GUARDIAN _____ DATE _____

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.

Child's Name:_____

Your child's growth and development is measured with developmental assessments. If your child currently has an IEP/IFSP, it would be beneficial to share a copy of this plan with us so we can work together to ensure that the guidelines are put into practice. You do not have to provide this information if you do not wish to do so.

☐ I am providing a copy of my child's IEP or IFSP.

☐ I am not providing a copy of my child's IEP or IFSP and/or this is not applicable to my child.

I acknowledge that I have received the 2016-2017 SOS AND LOL parent handbook. If I have any questions regarding the program's policies or procedures after I have read the handbook I will notify Executive Director, Cynthia Wright-Whitley, or Site Supervisor, Pamela Ramos immediately. I also agree to follow all rules and procedures that are outlined in the handbook.

Signature:_____ Date:_____

Printed Name:_____

NONDISCRIMINATION IN SERVICES

Admissions, the provisions of services, and referrals of clients shall be made without regard to race, color, religious creed, disability, ancestry, national origin (including limited English proficiency), age, or sex.

Program services shall be made accessible to eligible persons with disabilities through the most practical and economically feasible methods available. These methods include, but are not limited to, equipment redesign, the provision of aides, and the use of alternative service delivery locations. Structural modifications shall be considered only as a last resort among available methods.

Any parent or child (and/or their guardian) who believes they have been discriminated against, may file a complaint of discrimination with:

Reese Street Community Center d.b.a. Ayuda Community Center
4400 N. Marshall Street
Philadelphia, PA 19140

Department of Public Welfare
Bureau of Equal Opportunity
Room 223, Health & Welfare Building
PO Box 2675
Harrisburg, PA 17105

PA Human Relations Commission
Philadelphia Regional Office
110 N. 8th Street, Suite 501
Philadelphia, PA 19107

U.S. Department of Health and Human Services
Office for Civil Rights
Suite 372, Public Ledger Bldg.
150 South Independence Mall West
Philadelphia, PA 19106-9111

Commonwealth of Pennsylvania
DPW Bureau of Equal Opportunity
Southeastern Regional Office
801 Market Street, Suite 5034
Philadelphia, PA 19107

CHILD'S NAME:_____

PARENT/GUARDIAN NAME:_____ Date:_____

SIGNATURE:_____

AYUDA STAFF SIGNATURE: _____ Date:_____

AYUDA COMMUNITY CENTER
S.O.S. or L.O.L. AFTER/Before SCHOOL PROGRAM 2016-2017
PARENT AGREEMENT

1. I understand that I am enrolling my child, _____ for the 2016-2017 SOS or LOL After School Program.

2. I understand that the **$50 deposit is non-refundable** and **does** apply toward the total fee amount.

3. I understand that I am responsible for the entire fee per child which will be calculated on a sliding scale according to household income. I understand that payment is due on the 1**5th of every month for 9 months** unless otherwise stated on the registration form.

4. I understand that any bounced checks will be charged a fee of $12.00 to cover any bank fees incurred by Ayuda Community Center.

5. I understand that Ayuda is only able to provide this program for such a low cost because they rely on funding from the City of Philadelphia for Out of School Time programs. This funding is based on children's actual attendance in the after school program. Therefore:

    a. **Ayuda requires your child to attend at least two hours each day for at least four days a week for the SUPPORT OUR STUDENTS (K-5th grade) after school program**. If you are unable to commit to this, please do not enroll your child(ren) in the program. I also understand that in the event of any absences from the program, I will be responsible for fees for the time reserved, not actual time spent in the program. Therefore, all fees are non-refundable.

    b. **Ayuda requires your child to attend a minimum of 3 days per week for 90 minutes per day for students enrolled in the LIVING OUR LIVES (LOL –6th to 8th) After School Program**. If you are unable to commit to this, please do not enroll your child in the program. If my child(ren) does not attend the minimum requirement, they will either be dismissed from the LOL program or will have to pay the Full Fees of Art Classes enrolled.

6. I understand that if my child(ren) is (are) enrolled in the BEFORE CARE PROGRAM, program hours are from 6:00 a.m. to 8:15 a.m. Monday through Friday**. I understand that fees will be collected on a weekly basis ($10 per week) every Monday.** Ayuda will be responsible for each child to be dropped off at their respective schools in a timely fashion before school begins.

7. I understand that the normal after school program's hours are from 3:00 p.m.-6:00 p.m. Monday through Friday and that I am responsible for picking up my child/ren promptly. When half days are provided the program will be from 12:00p.m. – 6:00 p.m

8. I understand that there is a late fee charge which will be assessed beginning at 6:01 p.m. Ten dollars ($10) will be charged for every 15 minutes late (6:01pm-6:16pm-$10; 6:17pm-6:32pm-$20; 6:33pm-6:48pm-$30; 6:48pm-7:03pm-$40). All fees must be paid by the following day or the child will be dismissed from the program.

9. I understand that the program will be held at Hunting Park Christian Academy unless I am notified that the location will change to Cayuga Elementary School for a specific day. I also understand that the doors will be locked after 3:15 p.m. The doors will be monitored for parent pick-up between 5:00 and 6:00 p.m. If I have an emergency and must pick up my child(ren) before 5:00 p.m. I will call the office.

AYUDA COMMUNITY CENTER
S.O.S. or L.O.L. AFTER/Before SCHOOL PROGRAM 2016-2017
PARENT AGREEMENT

10. If a medical emergency arises, the program staff will first attempt to contact me. If I cannot be reached, the staff will contact my child's doctor. If the emergency is such that immediate hospital attention is necessary, an ambulance or emergency vehicle may take my child to the hospital which is determined by the emergency technicians.

11. In cases of illness, I understand that my child may not attend the program. If my child should become ill at the program, I understand that I will be called to pick up my child. I also understand that if the staff feels that my child has a contagious condition, then my child may not return to the program without a doctor's note, and/or evidence of treatment.

12. I understand that if the program staff feels it is necessary to meet with me, they can request a meeting at any time.

13. I understand that my child must obey all of the rules of Ayuda Community Center's SOS and LOL After/Before School Program. I understand that behavior problems will be addressed by the staff and will not be tolerated.

14. I understand that I must call the Program by 2:30 p.m. if my child is going to be absent that day for the after school program. I also understand that if my child misses four consecutive days they may be dismissed from the program. I further understand that if my child is absent from school he/she will not be allowed to attend the program for the day of the absence.

15. I understand that the program includes Biblical instruction from staff and volunteers.

16. I understand that this program may not suit my child. If my child is not willing to participate in all aspects of the program or is inconsistent in attendance, the Site Supervisor may dismiss my child from the program.

I have read all of the above statements and agree to adhere to all the stated policies and procedures of Ayuda Community Center's SOS and LOL After/Before School Program as stated here and in the Parent/Student Handbook, and give my child/ren permission to participate fully in this program.

I understand a copy of this agreement will be placed in my child's file.

_____

Child's Name

_____

Print Name

_____ _____

Parent/Guardian's Signature **Date**

Public Health Management Corporation
Out-of-School Time Project
Consent to Collect Information
September 12, 2016 to June 23, 2017
Agency Name: Reese Street Com. Ctr. d.b.a. Ayuda Community Center
Program Location and Model 4400 N. 6th Street, Philadelphia PA 19140

Purpose:
The City of Philadelphia's Department of Human Services (DHS) funds over 200 after-school programs through the Outof-School Time (OST) program. The City has a contract with Public Health Management Corporation (PHMC). PHMC manages the OST program your child attends. When you enroll your child in OST, PHMC will collect information from you to help manage the program. If you agree, we will also ask you and your children questions about OST to make the program better.

Process:
When you sign-up for an OST program, PHMC will ask you some questions about your child, such as his name, age and address. You will complete this information on the program's registration forms. This information will be entered into a database at PHMC. Staff at PHMC and the City will be able to see this information and use it to improve the OST program. OST staff may also visit the program and talk to your child about being at that program. This is a basic part of OST for every child and every after-school site.
To learn more about your experience with OST, PHMC may ask you and your child to complete short surveys. These surveys will be given at the start and at the end of the school year during regular after-school time. The survey will ask questions about what you and your child think about the program.

Information Privacy and Sharing:
The information that we collect about your child will not be shared with anyone outside of the OST program. All of the information is stored in a database that is protected by a password. Only approved staff at PHMC or the City can see the information.
We will never share any single child's answers. We will only share results from the survey for the OST program as a whole.

Voluntary Surveys:
You can decide if you want your child to participate in the OST surveys. You can decide not to participate. This will not in any way affect your child's chance to enroll in the program.
Questions: If you have any questions about this form, you may contact: Debby McGurk at PHMC, 215-825-8203 or ost@phmc.org.

PLEASE CHECK ONE OF THE BOXES and SIGN BELOW:

□ **Agreement to Participate: I have read and understand this form. I agree to allow my child to answer the surveys.**

□ **Refusal to Participate: I have read and understand this form. I do NOT give permission for my child to answer the surveys.**

Child's Name: _____

Parent/Guardian's Name: _____

Parent/Guardian Signature Date: _____

The City of Philadelphia
Out-of-School Time Project
CONSENT TO RELEASE EDUCATION RECORDS UNDER FERPA

Student: _____ Student ID #: _____

The Out-of-School Time Project ("OST") is a Philadelphia effort to improve the well-being of children and youth through effective academic support, enrichment and youth development activities during non-school hours. OST programming provides safe, constructive activities to children when they are not in school, and has been demonstrated to improve in-school performance.

In order to assess and improve the quality of OST programs, The City of Philadelphia Department of Human Services (the "City") asks for permission to collect personally identifiable information from education records regarding children's school performance. The City will collect standardized test scores, report cards and school attendance, disciplinary and other relevant school records ("education records"). The City will use these education records to measure the impact of OST programming on childrens' school performance and to improve the quality of those programs.

I am the parent or guardian of the student named above ("Student"). 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 my Student's OST program ("Recipients").

The School District releases these education records in connection with the Student's participation in an OST 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 (or Student's signature, if Student is 18 years old or an emancipated minor) Date

_____ _____
Name of school in which Student is currently enrolled Student's Grade

Reese Street Community Center d.b.a. Ayuda Community Center _____
Name of Student's OST Provider Agency Student's Date of Birth

4400 N. 6th Street, Philadelphia, PA 19140
Name of Student's OST Provider Location