



Search for and apply to DYCD Programs Online!
<https://discoverdycd.dyccdconnect.nyc/home>

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



DYCD Universal Participant Intake: Youth & Adult Application (Ages 13 & Younger)

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 myself <input type="checkbox"/> I am a parent or guardian completing this application for my child <input type="checkbox"/> I am a relative/non-relative, completing this application on behalf of the applicant </p>			
Applicant's First Name:		Applicant's Last Name:	
Applicant's Date of Birth (MM/DD/YEAR):		MI:	
Applicant's Apt. Number:		Applicant's Primary Address (Number and Street):	
Applicant's City:		Zip Code:	
Applicant's Sex at Birth (Select One): <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> X (not female or male) <input type="checkbox"/> Not sure	Applicant's Race (Select all that Apply): <input type="checkbox"/> American Indian and Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Middle Eastern/North African <input type="checkbox"/> Native Hawaiian and Other Pacific Islander <input type="checkbox"/> White or Caucasian <input type="checkbox"/> Other _____	Applicant's Ethnicity (Select One): <input type="checkbox"/> Hispanic or Latinx <input type="checkbox"/> Not Hispanic or Latinx	
<input type="checkbox"/> Applicant lives in a NYCHA Development (please provide name) _____			

Part II: Applicant's (or Parent/Guardian's) Contact Information

Applicant's Contact Information

For youth without contact information, skip to the next section to provide parent/guardian contact information

Write down phone numbers for the applicant and check the preferred method of contact:

- Home _____ Cell _____ No Email
 Work _____ Email _____ US Mail

Parent/Guardian Information

This section is required for Applicants under 18

Parent/Guardian Name: _____

Write down all phone numbers and check the best number to call in case of an emergency:

- Home _____ Cell _____ No Email
 Work _____ Email _____

Address: <input type="checkbox"/> Same as Applicant	City:	State:	Zip Code:
---	--------------	---------------	------------------

Emergency Contact Information

At least one emergency contact must be identified

1	Emergency Contact #1 Name:	Relationship to Participant: <input type="checkbox"/> Emergency contact is parent/guardian of participant		
	Write down all phone numbers and check the best number to call in case of an emergency:			
	<input type="checkbox"/> Home _____ <input type="checkbox"/> Cell _____ <input type="checkbox"/> No Email <input type="checkbox"/> Work _____ <input type="checkbox"/> Email _____			
	Address: <input type="checkbox"/> Same as Applicant	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 check the best number to call in case of an emergency:			
	<input type="checkbox"/> Home _____ <input type="checkbox"/> Cell _____ <input type="checkbox"/> No Email <input type="checkbox"/> Work _____ <input type="checkbox"/> Email _____			
	Address: <input type="checkbox"/> Same as Applicant	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: _____
--------------------	--------------------	--------------------

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
 Obtained High School Diploma
 Obtained High School Equivalency

4-Year College/University: Freshman Sophomore
 Junior Senior Obtained Bachelor's Degree

Doctorate Degree:
 Some Doctorate degree credits, but no degree attained
 Obtained Doctorate Degree

Other:
 Obtained Foreign Degree
 No Formal Schooling Attained

Community College: 1st year 2nd Year 3rd year
 4th Year + Obtained Associate's Degree

Master's Degree:
 Some Master's Degree credits, but no degree attained
 Obtained Master's Degree

Professional Degree:
 Some Professional Degree credits (e.g. MD, DDS, DVM, LLB, JD), but no degree attained
 Obtained Professional Degree (e.g. MD, DDS, DVM, LLB, JD)

Vocational/Trade School:
 Some Vocational or Trade School credits, but no certificate or degree attained
 Obtained a certificate or degree from a Vocational or Trade school

Applicant's Current Work Status (Select One):

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

Required for Full-Time Students

Student ID/OSIS:

School Type:

Public Charter Private 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</p> <p><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 style="width: 100%;"> <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									

<p>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):</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to Answer</p>	<p>If you would like to be contacted about signing up for public health insurance, what is your preferred method of contact? (Select One):</p> <p><input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> US Mail</p> <p><input type="checkbox"/> Via provider <input type="checkbox"/> Decline to Answer</p>
--	--

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):

- | | |
|---|--|
| <input type="checkbox"/> Single Parent - Female | <input type="checkbox"/> Two Adults – No Children |
| <input type="checkbox"/> Single Parent - Male | <input type="checkbox"/> Two Parent Household |
| <input type="checkbox"/> Single Person - No children | <input type="checkbox"/> Multigenerational Household |
| <input type="checkbox"/> Non-related adults with children | <input type="checkbox"/> Other: _____ |

Applicant's Housing Type (Select One):

- | | | |
|---------------------------------------|-----------------------------------|--|
| <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):

- | | | |
|-----------------------------------|---|-----------------------------------|
| <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 or more | |

Total Household Income in the last 12 Months (Select One):

- | | | |
|---|---|--|
| <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): _____



Consent to Make Referrals and Share Information

The New York City Department of Youth and Community (DYCD) invests in programs and services to help our communities and the people who live here. We want to make sure you know about them and make it easy for you to apply.

Why we need your permission

With it, we can:

- send you information about DYCD-funded programs and services you can apply for, and
- share information from your DYCD Participant Application each time you apply.

What we share

We'll only give information to show you qualify or help you enroll in DYCD-funded programs.

Who sees your information and how we protect it

Only authorized DYCD and funded program staff can see it. We don't share it with others except to:

- decide if you're eligible for services,
- enroll you in programs and services, and
- track the results of the services you receive

Please read below, check one of the boxes, and fill in the rest.

I understand why DYCD needs my consent to:

- send me information about programs and services I can apply for,
- refer me to DYCD-funded programs, and/or
- share information from my DYCD Participant Application with the programs I apply for

Yes, I give my permission

No, I do not give my permission

Full Name of Participant (please print)

Signature of Participant (or Parent/Guardian for participants under 18 years old)

Date

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

**CHILD CARE EMPLOYEE, VOLUNTEER, PARENT, CHILD AND ESSENTIAL VISITORS
HEALTH SCREENING ONE-TIME ATTESTATION**

Before entering a child care program, employees, volunteers, parents, children and essential visitors **must complete a health screening questionnaire daily. In addition, each employee, volunteer, parent, child and essential visitor must sign and submit this form to the program one time.** Employees, volunteers, parents, children and essential visitors must answer all questions and take their temperature daily to confirm a body temperature lower than 100.0 degrees Fahrenheit. If anyone answers “Yes” to any of the questions below, they cannot enter the child care program. A parent or guardian is responsible for completing daily screening on behalf of their child(ren).

Self-Screening:

Below are the self-screening questions that employees, volunteers, parents, children and essential visitors are required to answer **daily**. If any of the answers to the below questions are “Yes,” individuals **cannot** enter the program. If the answers are “No” to all the following questions, individuals may enter the program. If employees, volunteers, parents, children and essential visitors cannot take their temperature at home, but answer “No” to all other questions, they may report to the program to have their temperature taken on site.

1. Is your temperature higher than or equal to 100.0 degrees Fahrenheit?
2. Have you had any known contact with a person confirmed or suspected to have COVID-19 in the past 14 days?
3. Are you currently experiencing ANY of the following symptoms?
 - o Cough (new or worsening)
 - o Shortness of breath (new or worsening)
 - o Trouble breathing (new or worsening)
 - o Fever
 - o Chills
 - o Muscle pain (new or worsening)
 - o Headache (new or worsening)
 - o Sore throat (new or worsening)
 - o New loss of taste
 - o New loss of smell
4. Have you tested positive for COVID-19 through a diagnostic test in the past 14 days?

If you have answered “NO” to all questions, you have passed and may enter the program.

If you have answered “YES” to any question, you will not be allowed to enter the program.

Attestation: By signing this document, I agree that I will self-monitor these symptoms each day and report the outcome per the instructions above and will not enter any child care program if any of the above symptoms or conditions are present.

Signature	/ /
Signature	Date
	/ /
	Date

Note: This document must be signed and returned to the program prior to entry. A signed copy needs to be provided only once. The child care program must retain a copy for their records.