BOYS & GIRLS CLUB OF METRO QUEENS

PARTICIPANT APPLICATION

Applicant's First Name

Applicant's Last Name

Middle Initial

Applicant's Primary Address (Number and Street)

Apt. #

Borough

Zip Code

Applicant's (or Parent/Guardian's) Cell Phone Number

Applicant's (or Parent/Guardian's) Home Phone Number

Applicant's Email Address

Applicant's Preferred Method of Contact

- ☐ Cell Phone
- ☐ Home Phone
- ☐ Email
- ☐ Other _____

Emergency Contact Number

Emergency Contact Phone Number

Applicant's Date of Birth (MM/DD/YEAR)

Applicant's Sex

- ☐ Female
- ☐ Male

Applicant's Ethnicity

(Select One)

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino

Applicant's Race

(Select all that apply)

- ☐ Black or African-American
- ☐ Native Hawaiian & Other Pacific Islander
- ☐ White or Caucasian
- ☐ American Indian & Alaska Native
- ☐ Asian
- ☐ Other _____

How well does the Applicant Speak English?

(Select One)

- ☐ Fluent/Very Well
- ☐ Well
- ☐ Not Well Not
- ☐ Well at All

Parents in the Military?

- ☐ Yes
- ☐ No

Applicant's Primary Languages

(Select One)

- ☐ English
- ☐ Albanian
- ☐ Arabic
- ☐ Bengali
- ☐ Chinese
- ☐ French
- ☐ Fulani
- ☐ German
- ☐ Greek
- ☐ Gujrati
- ☐ Hatian/Croole
- ☐ Hebrew
- ☐ Hindi
- ☐ Hungarian
- ☐ Italian
- ☐ Japanese
- ☐ Korean
- ☐ Kru/bo/Yorba
- ☐ Mande
- ☐ Punjabi
- ☐ Persian
- ☐ Polish
- ☐ Portoguese
- ☐ Romanian
- ☐ Russian
- ☐ Spanish
- ☐ Tagalog
- ☐ Turkish
- ☐ Urdu
- ☐ Vielnamase
- ☐ Yiddish
- ☐ Other:_____
- ☐ Polish

Other Languages Spoken by Applicant

(Select all That Apply)

- ☐ English
- ☐ Albanian
- ☐ Arabic
- ☐ Bengali
- ☐ Chinese
- ☐ French
- ☐ Fulani
- ☐ German
- ☐ Greek
- ☐ Gujrati
- ☐ Hatian/Croole
- ☐ Hebrew
- ☐ Hindi
- ☐ Hungarian
- ☐ Italian
- ☐ Japanese
- ☐ Korean
- ☐ Kru/bo/Yorba
- ☐ Mande
- ☐ Punjabi
- ☐ Persian
- ☐ Polish
- ☐ Portoguese
- ☐ Romanian
- ☐ Russian
- ☐ Spanish
- ☐ Tagalog
- ☐ Turkish
- ☐ Urdu
- ☐ Vielnamase
- ☐ Yiddish
- ☐ Other:_____
- ☐ Polish

BOYS & GIRLS CLUB OF METRO QUEENS

PARTICIPANT APPLICATION

Household Size

- ☐ One
- ☐ Two
- ☐ Three
- ☐ Four
- ☐ Five
- ☐ Six
- ☐ Seven
- ☐ Eight
- ☐ Nine
- ☐ Ten
- ☐ Eleven
- ☐ Tweleve
- ☐ Thirteen
- ☐ Fourteen
- ☐ Fifteen
- ☐ Sixteen
- ☐ Seventeen
- ☐ Eighteen
- ☐ Nineteen
- ☐ Twenty

Total gross annual income in last 12 months

- ☐ $0
- ☐ $1 to $11,880
- ☐ $11,881 to $16,020
- ☐ $16,021 to $20,160
- ☐ $20,161 to $24,300
- ☐ $24,301 to $28,440
- ☐ $28,441 to $32,580
- ☐ $32,581 to $36,730
- ☐ $36,731 to $40,890
- ☐ $40,891 to $50,000
- ☐ $50,001 to $60,000
- ☐ $60,001 to $70,000
- ☐ $70,001 to $80,000
- ☐ $80,001 to $90,000
- ☐ $90,001 to $100,000
- ☐ $100,000+
- ☐ Decline to answer

Head of Household : (Select all that apply)

- ☐ Single Parent - Female
- ☐ Single Parent - Male
- ☐ Two Adults - No Children
- ☐ Two Parents Household
- ☐ Single Person - No Children
- ☐ Other

Receive Free and Reduced Lunch?

- ☐ Yes
- ☐ No

Applicant's Housing type: (Select One)

- ☐ Own
- ☐ Rent
- ☐ Shelter
- ☐ Homeless
- ☐ Runaway Youth
- ☐ Other _____
- ☐ NYCHA: Development _____

Sources of Applicant's Household Income: (Select all that apply)

- ☐ Employement Wages
- ☐ Unemployement Wages
- ☐ Supplemental Nutrition Assistance Program (SNAP)
- ☐ Temporary Assistance for Needy Families (TANF)
- ☐ Social Security Worker's
- ☐ Supplemental Security Insurance (SSI)
- ☐ Compensation Pension
- ☐ Safety Net/Home Relief

Applicant's School type : (Select one)

- ☐ Full-Time Student
- ☐ Part-Time Student
- ☐ Not in School

Current Grade : (Select one)

Elementary School: ☐ Pre-K ☐ K ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th Middle School: ☐ 6th ☐ 7th ☐ 8th High School: ☐ 9th ☐ 10th ☐ 11th ☐ 12th

Community College: ☐ 1st yr. ☐ 2nd yr. ☐ 3rd yr. ☐ 4th yr. ☐ 5th yr. ☐ 6th yr. Collge/University: ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior

Other: ☐ High School Equivalency (HSE) ☐ Vocational/Trade School ☐ Foreign Degree

Is applicant or is any member of the household (0-64) years of age covered by Medicare, Medicaid, Child Health Plus, or Private Medical Insurance? (Select One)

- ☐ Yes
- ☐ No

Is the applicant any of the following? (Select all that apply)

- ☐ Disabled
- ☐ Pharent/Guardian
- ☐ Foster Care Participant
- ☐ Offender/Justice Involved
- ☐ Veteran
- ☐ Decline to answer

If no, do you want to be contacted by somone else with information about signing up for public health insurance programs? (Select One)

- ☐ Yes
- ☐ No

If yes, how would you like to be contacted about this issue? (Select One)

- ☐ Email
- ☐ Phone
- ☐ U.S. Mail
- ☐ Via Provider

Would you be interested in registering to vote? (Select One)

- ☐ Yes
- ☐ No

BOYS & GIRLS CLUB
OF METRO QUEENS

PARTICIPANT APPLICATION

School Information

- Student Id/OSIS: _____
- School Type: ☐ Public ☐ Charter ☐ Private ☐ Other
- School Name: _____
- School Address: _____ Borough: _____ Zip Code:_____

Participant Safety: IF there is any emergency, please contact the following individuals.

NAME _____ RELATIONSHIP TO PARTICIPANT:

Pick Up* _____

Address _____

City, State _____

Zip Code _____

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

Contact Home _____

Cell _____

Work _____

Email* _____ No Email

NAME _____ RELATIONSHIP TO PARTICIPANT:

Pick Up* _____

Address _____

City, State _____

Zip Code _____

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

Contact Home _____

Cell _____

Work _____

Email* _____ No Email

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 in program.

- ☐ Allergies to food
- ☐ Allergies to medications
- ☐ Allergies other (please specify)
- ☐ Asthma
- ☐ Behavioral/Emotional Issues
- ☐ Convulsions/Seizures
- ☐ Congestive Illness (e.g., heart murmur/disease, blood pressure)
- ☐ Corrective Devices (e.g, Crutches, hearing aid, eye glasses)
- ☐ Diabetes
- ☐ Individualized Education Plan
- ☐ Obesity
- ☐ Other (please specify)
- ☐ Physical Disabilities
- ☐ Pregnant

Check off all that apply.

- ☐ Does your child have special health care needs that require treatment and/or medication?
- ☐ Does your child take medication for any condition or illness?
- ☐ Updated Medical information on File:
- ☐ Are there any activities your child cannot participate in? (If so, please specify below)
- ☐ Activities your child cannot participate in:

BOYS & GIRLS CLUB
OF METRO QUEENS

PARTICIPANT APPLICATION

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:_____

Signatures:

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 or to access additional funding.

I have completed this application for my child.

Parent/Guardian: _____ _____ _____
(Print) (Sign) (Date)

I have completed this application for myself.
Applicant: (18 and older}_____ _____ _____
(Print) (Sign) (Date)

Organization:_____

Intake Specialist/Staff: _____ Date: _____

BOYS & GIRLS CLUB
OF METRO QUEENS

PARTICIPANT APPLICATION

Consent to Collect and Share Student Information

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 BGCMQ, 21 Century and DOE staff who manage the data systems and prepare research reports and program analyses. The limited number of 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 BGCMQ, DOE and 21 Century and will be secured and protected In the BGCMQ 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.

Please check Yes or No to each of the following statements:

- I understand why BGCMQ is asking my permission to access the information listed above from my child's student records, and I give permission to BGCMQ to share that information with DOE and 21 Century on an ongoing basis.

  _____Yes, I give my permission _____No, I do not give my permission

- I understand why BGCMQ is asking my permission to share information about my child collected with 21 Century and DOE staff and *I* give my permission to BGCMQ to .share information with DOE and 21 Century on an ongoing basis.

  _____Yes, I give my permission _____No, I do not give my permission

Student/Applicant Name: _____

Parent/GuardianName:_____

Parent/Guardian Signature:_____ Date:_____

Additional Parent/Guardian Name:_____

Additional Parent/Guardian Signature: *(optional)*

_____

BOYS & GIRLS CLUB
OF METRO QUEENS

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 at off-site events and events taking place in the usual program location. In some cases, they may photograph, videotape, 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 in printed and electronic media such as brochures, books, print and email newsletters, DVDs and videos, websites, social media and blogs (collectively, "Media"). These images, videos and interviews may be used by Boys and Girls Club of Metro Queens and third-party organizations that collaborate with 21 Century, without compensation and without further approval, solely for non-profit, non-commercial purposes.

If, In the course of participating in program activities or special events, any original work is created by a participant, 21 Century may use the created work in any and all Media to promote the program or for other informational, non-profit and non-commercial purposes, without compensation and without further approval.

- 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 program.

  _____Yes, I give my permission _____ No, you do not have permission

Consent (or 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 before.

_____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

After-School Survey Consent Form

Boys and Girls Club of Metro Queens

PROGRAM EVALUATION CONSENT

The After-School program that your child attends is evaluated each year to make changes that improve the quality of the program and demonstrate to New York State and the U.S. Government that after-school programs contribute to the well-being of our children. New York State is interested in knowing if the program participants are gaining positive youth development skills such as self-confidence, engagement in school, life skills, positive choices and positive core values.

With your permission, your child and others will be asked to complete a brief survey about what they think of the program and how going to the program has affected them. All responses are anonymous and will be kept confidential. The survey will include questions about the program as well as about your child's feelings about the program and some things coming to the program might have changed about them. Some sample questions are:

Because of coming to the after school program:

I get along better with people my own age.	☐ Yes	☐ Kind of	☐ Not Really
I am better at making friends.	☐ Yes	☐ Kind of	☐ Not Really
I try harder in school.	☐ Yes	☐ Kind of	☐ Not Really
I make better decisions.	☐ Yes	☐ Kind of	☐ Not Really

Your child's participation is strictly voluntary. Your child is free to refuse participation or skip questions. Participation in the survey is not required nor does it affect program attendance in a positive or negative way.

There may be some risk to your child. He/she may be embarrassed or uncomfortable to answer questions about self-esteem or personal behaviors. Your child's name will not appear on any survey form or report. All responses are confidential. The only exceptions to this are: if information is revealed concerning suicide, homicide, child abuse and/or neglect, the law requires that information to be reported to appropriate agencies. In addition, should any information in this survey be the subject of a court order or lawful subpoena, this program might be compelled to disclose the information.

If you have any questions about this survey or your child's rights, or if you wish to have a copy of this survey, please contact:_____718-441-6050_____

I have read and understand the above survey evaluation description. For things I do not understand, I have asked for and received a satisfactory explanation. I agree to have my child participate in this evaluation through _____ (Provide appropriate date)

I understand that my child's privacy will be protected because my child's responses cannot be traced to my child.

Child Participant's Name (Print):_____

Parent/Guardian's Name (Print): _____

Parent/Guardian's Signature:_____

(If child has two legal guardians, both signatures are recommended)

Parent/Guardian's Name (Print): _____

Parent/Guardian's Signature:_____

Date:_____

After-School Survey Agreement Form
Student Agreement
To
Participate in Program Evaluation

As a participant I agree to be in a study to answer some questions about my feelings and opinions about my after- school program. These questions are being asked to help program planners make it a better program for me and the other participants.

I understand that my answers are private and my name will not be on any answer sheet. I will not get a grade for my answers and no one will discuss my answers unless I ask them to. I agree to participate in this survey through _____ (Insert appropriate date) as long as I am participating in the after-school program.

I can answer all the questions, or leave some blank without getting into trouble. If I do not answer the questions, I am still able to attend.

Child's Name (Print): _____

Child's Signature: _____

Date of Birth: _____

Adult Witness (Print): _____

Adult Witness Signature: _____

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name | **First Name** | **Middle Name** | **Sex** ☐ Female ☐ Male | **Date of Birth** *(Month/Day/Year)* ___ ___ / ___ ___ / ___ ___ ___ ___

Child's Address | **Hispanic/Latino?** ☐ Yes ☐ No | **Race** *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other _____

City/Borough | **State** | **Zip Code** | **School/Center/Camp Name** | **District** __ __ **Number** __ __ __

Phone Numbers Home _____ Cell _____ Work _____

Health insurance (including Medicaid)? ☐ Yes ☐ No

☐ **Parent/Guardian** ☐ **Foster Parent** **Last Name** **First Name** **Email**

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

Attach MAF if in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma ***(check severity and attach MAF)***: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes ***(attach MAF)***
☐ Orthopedic injury/disability
Explain all checked items above.

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) _____
☐ ***Addendum attached.***

Medications ***(attach MAF if in-school medication needed)***

☐ None ☐ Yes *(list below)*

_____
_____
_____
_____

PHYSICAL EXAM **Date of Exam:** ___ /___ /___

Height _____ **cm** (___ ___ %ile)

Weight _____ **kg** (___ ___ %ile)

BMI _____ **kg/m²** (___ ___ %ile)

Head Circumference *(age ≤2 yrs)* _____ **cm** (___ ___ %ile)

Blood Pressure *(age ≥3 yrs)* _____ / _____

General Appearance:

☐ Physical Exam WNL

Nl Abnl	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*
☐ ☐ Psychosocial Development	☐ ☐ HEENT	☐ ☐ Lymph nodes	☐ ☐ Abdomen	☐ ☐ Skin
☐ ☐ Language	☐ ☐ Dental	☐ ☐ Lungs	☐ ☐ Genitourinary	☐ ☐ Neurological
☐ ☐ Behavioral	☐ ☐ Neck	☐ ☐ Cardiovascular	☐ ☐ Extremities	☐ ☐ Back/spine

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

Validated Screening Tool Used? ☐ Yes ☐ No

Date Screened ___/___/___

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: _____

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< 1 year ☐ Breastfed ☐ Formula ☐ Both

≥ 1 year ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes *(list below)*

SCREENING TESTS	*Date Done*	*Results*
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	___/___/___	_____ µg/dL
	___/___/___	_____ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	___/___/___	☐ At risk *(do BLL)* ☐ Not at risk
—— Child Care Only ——		
Hemoglobin or Hematocrit	___/___/___	_____ g/dL _____ %

Hearing	*Date Done*	*Results*
< 4 years: gross hearing	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*
OAE	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*
≥ 4 yrs: pure tone audiometry	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*

Vision	*Date Done*	*Results*
<3 years: Vision appears:	___/___/___	☐ *Nl* ☐ *Abnl*
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right _____ /_____ Left _____ /_____ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental

Visible Tooth Decay	☐ Yes ☐ No
Urgent need for dental referral *(pain, swelling, infection)*	☐ Yes ☐ No
Dental Visit within the past 12 months	☐ Yes ☐ No

CIR Number

Physician Confirmed History of Varicella Infection ☐

Report only positive immunity:

IMMUNIZATIONS – DATES

															IgG Titers	Date
DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___			Tdap	___/___/___	___/___/___			Hepatitis B	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___			MMR	___/___/___	___/___/___			Measles	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___			Varicella	___/___/___	___/___/___			Mumps	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___			Mening ACWY	___/___/___	___/___/___			Rubella	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___			Hep A	___/___/___	___/___/___			Varicella	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___			Rotavirus	___/___/___	___/___/___			Polio 1	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___			Mening B	___/___/___	___/___/___			Polio 2	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___			Other _____	___/___/___	_____ ___/___/___			Polio 3	___/___/___

ASSESSMENT ☐ **Well Child** (Z00.129) ☐ **Diagnoses/Problems** *(list)* **ICD-10 Code**

_____ _____
_____ _____
_____ _____

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions (*specify*) _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: __ __/__ __/__ __

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other _____

Health Care Practitioner Signature | Date Form Completed ___/___/___

Health Care Practitioner Name and Degree *(print)* | Practitioner License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone | Fax | Email

DOHMH ONLY **PRACTITIONER I.D.**

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Date Reviewed: ___/___/___ **I.D. NUMBER**

REVIEWER:

FORM ID#