

\_\_\_ ES  
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Search for and apply to DYCD Programs Online!  
<https://discoverdycd.dycdconnect.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><b>For the purposes of this application, applicant refers to the person applying to receive services. Select one:</b></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):		Applicant's Primary Address (Number and Street):	
Applicant's Apt. Number:	Applicant's City:	Zip Code:	
<b>Applicant's Sex at Birth</b> (Select One):  <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> X (not female or male) <input type="checkbox"/> Not sure	<b>Applicant's Race</b> (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 _____		<b>Applicant's Ethnicity</b> (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 \_\_\_\_\_

<b>Address:</b>  <input type="checkbox"/> Same as Applicant	<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
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### Emergency Contact Information

At least one emergency contact must be identified

<b>1</b>	<b>Emergency Contact #1 Name:</b>	<b>Relationship to Participant:</b>  <input type="checkbox"/> Emergency contact is parent/guardian of participant		
	<b>Write down all phone numbers and check the best number to call in case of an emergency:</b>			
	<input type="checkbox"/> Home _____ <input type="checkbox"/> Cell _____ <input type="checkbox"/> No Email <input type="checkbox"/> Work _____ <input type="checkbox"/> Email _____			
<b>Address:</b>  <input type="checkbox"/> Same as Applicant		<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>2</b>	<b>Emergency Contact #2 Name:</b>	<b>Relationship to Participant:</b>  <input type="checkbox"/> Emergency contact is parent/guardian of participant		
	<b>Write down all phone numbers and check the best number to call in case of an emergency:</b>			
	<input type="checkbox"/> Home _____ <input type="checkbox"/> Cell _____ <input type="checkbox"/> No Email <input type="checkbox"/> Work _____ <input type="checkbox"/> Email _____			
<b>Address:</b>  <input type="checkbox"/> Same as Applicant		<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>

*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  1<sup>st</sup>  2<sup>nd</sup>  3<sup>rd</sup>  
 4<sup>th</sup>  5<sup>th</sup>

**Middle School:**  6<sup>th</sup>  7<sup>th</sup>  8<sup>th</sup>

**High School:**  9<sup>th</sup>  10<sup>th</sup>  11<sup>th</sup>  12<sup>th</sup>

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:**  1<sup>st</sup> year  2<sup>nd</sup> Year  3<sup>rd</sup> year

4<sup>th</sup> 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):**

Employed Full-Time

Employed Part-Time

Retired

Unemployed (Short-Term, 6 months or less)

Unemployed (Long-term, more than 6 months)

Unemployed (Not in labor force)

Migrant Seasonal Farm Worker

Not applicable (applicant is under 14 years of age)

*Required for Full-Time Students*

**Student ID/OSIS:**

**School Type:**

Public  Charter  Private  Other \_\_\_\_\_

<b>School Name:</b>		
<b>School Address:</b>	<b>City:</b>	<b>Zip Code:</b>

### 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.

<p><b>Does the applicant have any allergies? (food, medication, etc.)</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes _____</p>
<p><b>Does the applicant have asthma?</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes _____</p>
<p><b>Does the applicant have special health care needs?</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes _____</p>
<p><b>Does the applicant take medication for any condition or illness?</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes _____</p>
<p><b>Are there activities the applicant cannot participate in?</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes _____</p>
<p><b>Please provide any additional health information details:</b></p> <p><input type="checkbox"/> N/A</p>

<p><b>Please list any accommodation(s) you are requesting for yourself/the applicant:</b></p> <p><input type="checkbox"/> N/A</p>
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#### Applicant's Health Insurance Status

<p><b>Does the applicant have health insurance? (Select One):</b></p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><input type="checkbox"/> Decline to Answer</p>	<p><b>If yes, what kind of health insurance does the applicant have?</b> (Check all that Apply):</p> <table style="width: 100%; border: none;"> <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									

**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):**

- Yes  No  Decline to Answer

**If you would like to be contacted about signing up for public health insurance, what is your preferred method of contact? (Select One):**

- Email  Phone  US Mail  
 Via provider  Decline to Answer

### 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?  Yes  No  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

**CONSENT FORM FOR COVID-19 TESTING**

**What is this form?**

We are seeking your consent to test your child for COVID-19 infection. The New York City Department of Education (NYC DOE) and New York City Department of Youth and Community Development (DYCD), working with NYC Health + Hospitals and the New York City Department of Health and Mental Hygiene, have partnered with laboratories and other providers to test Summer Rising participants, teachers, and staff members for COVID-19 infection.

**How often would you test my child?**

We are arranging for our laboratory and provider testing partners to come to every Summer Rising program periodically to test some of the participants, teachers, and staff. If you consent, your child may be selected for testing on one or more of these occasions in accordance with program guidelines. In addition, your child may also be tested throughout the duration of the program (1) in accordance with state and city mandates, or (2) if they exhibit one or more symptoms of COVID-19, or (3) if they are a close contact of a participant, teacher, or staff person with COVID-19 infection.

**What is the test?**

**If you consent**, your child will receive a free diagnostic test for the COVID-19 virus. Collecting a specimen for testing involves inserting a small swab, similar to a Q-Tip, into the front of the nose and/or collecting saliva (spit).

**How will I know if my child tests positive?**

If your child has a specimen collected for testing at Summer Rising, we will send information home with them to let you know. COVID-19 test results will generally be provided within 48-72 hours.

**What should I do when I receive my child’s test results?**

If your child’s test results are positive, please contact your child’s doctor immediately to review the test results and discuss what you should do next. You should keep your child at home and inform your child’s Summer Rising program coordinator. If your child’s test results are negative, this means that the virus was not detected in your child’s specimen. Tests **sometimes** produce incorrect negative results (called “false negatives”) in people who have COVID-19. If your child tests negative but has symptoms of COVID-19, or if you have concerns about your child’s exposure to COVID-19, you should call your child’s doctor. If you need help finding a doctor, call (844) NYC-4NYC.

**TO BE COMPLETED BY PARENT, GUARDIAN OR ADULT PARTICIPANT**

**Parent/Guardian Information**

Parent/Guardian Print Name:	
Parent/Guardian Address:	
Parent/Guardian Tel./Mobile #:	
Parent/Guardian Email address:	
Best way to contact you	

**Child Information**

Child Print Name:			
Child School ID/OSIS # (if known):		Child Date of Birth:	
Child Summer Rising Program			
Child Home Address:			

### NOTIFICATION OF INFORMATION SHARING

The law allows some information about your child to be shared with and among certain New York City and New York State agencies and their contracted service providers, including those listed below. This information will be shared only for public health purposes, which may include notifying close contacts of your child if they have been exposed to COVID-19, and taking other steps to prevent the further spread of COVID-19 in your community. Information about your child that may be shared with these agencies and service providers conducting COVID-19 Testing includes your child’s name and COVID-19 test results, date of birth/age, gender, race/ethnicity, Summer Rising program name(s), teacher(s), cohort/pod, enrollment and attendance history, and program participation, names of other family members or guardians, address, telephone, mobile number, and email address. Sharing of information about your child will **only** be done in accordance with applicable law and City policies protecting privacy and the security of your child’s data.

<ul style="list-style-type: none"> <li>• NYC Department of Education</li> <li>• NYC Department of Health and Mental Hygiene</li> <li>• NYS Department of Health</li> </ul>	<ul style="list-style-type: none"> <li>• NYC Department of Youth and Community Development</li> <li>• NYC Health and Hospitals Corporation</li> <li>• Contracted Service Providers for COVID-19 Testing</li> </ul>
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### CONSENT

By signing below, I attest that:

- I have signed this form freely and voluntarily, and I am legally authorized to make decisions for the child named above.
- I consent for my child to be tested for COVID-19 infection.
- I understand that my child may be tested at multiple times through September 1, 2021, and that testing may occur (1) on days scheduled by the NYC DOE and/or DYCD in accordance with program guidelines or state and city mandates, or (2) if they exhibit one or more symptoms of COVID-19, or (3) if they are a close contact of a participant, teacher, or staff person with COVID-19 infection.
- I understand that this consent form will be valid through September 1, 2021, unless I notify the designated contact person from my child’s Summer Rising program **in writing** that I revoke my consent.
- I understand that if I revoke my consent or refuse to sign, my child may not be allowed to participate in Summer Rising’s in-person programming.
- I understand that my child’s test results and other information may be disclosed as permitted by law.
- I understand that if I am a participant age 18 or older, or may otherwise legally consent for my own health care, references to “my child” refer to me and I may sign this form on my own behalf.

Signature of Parent/ Guardian (if child is under age 18)		Date
Signature of Participant (if age 18 or over or otherwise authorized to consent)		Date