Goddard Riverside
INVESTING IN PEOPLE, STRENGTHENING COMMUNITY

NYC Department of Youth & Community Development | Beacon Centers of New York City

BEACON PROGRAM 2021-2022
154 West 93rd Street, NY, NY 10025
212-866-0009 or 212-666-3026

August 16, 2021

Hi families.

We are pleased to announce pre-registration for our After School Program for youth in Grades K-8. We hope you and your family are staying safe during these unprecedented times. Goddard Riverside is expected to open fully in-person at Joan of Arc Complex based on Department of Education/Department of Health guidelines.

We are continuing our dedication to engage our youth in quality activities giving them an opportunity to learn, grow and explore new ideas. We welcome you back.

We are awaiting information on any restrictions regarding youth attending schools other that our host schools: PS333 (Manhattan School for Children), MS258 (Community Action School) and MS 256 (Lafayette Academy).

Once program begin is scheduled to begin on Monday, September 20 (subject to change based on the public-school). Participants will be grouped by grade and participate in all activities together. Wearing masks will be mandatory for all youth and staff, hand sanitizer will be available, and we will be practicing physical distancing. During dismissal, children allowed to go home will be dismissed at the front entrance. For children needing pick-up, your child will be brought to you at the front entrance once we have been informed you have arrived. Your child can only attend in-person on days they attend school.

You may register your child using the attached forms or you can download them from website www.goddard.org and submit to agomez@gomez@goddard.org or rbaptiste@goddard.org. Please submit completed forms with supporting documents at your earliest convenience.

- **For our Summer Camp participants: submit After School Information Update Form (attached)**
- **For all others complete Universal Participant Intake Application (paper form or online at https://discoverdycd.dycdconnect.nyc/home)**
- For all Yearly Medial forms (cannot be older than 1 year) unless submitted during summer
- Proof of Income (e.g., copies of 2020 W-2 form, 2 Pay Stubs, Budget Letter or Benefit Card)
- Income Eligibility form

If you have any questions or concerns, please don't hesitate to reach out to us at 212-866-0009 or agomez@goddard.org or rbaptiste@goddard.org.

Thanks for your past, present and future cooperation, and support. Hope to see you all very soon.

Sincerely,

The Beacon Staff Team

Goddard Riverside
INVESTING IN PEOPLE, STRENGTHENING COMMUNITY

NYC Department of Youth & Community Development | Beacon CENTERS OF NEW YORK CITY

BEACON PROGRAM 2021-2022
154 West 93rd Street, NY, NY 10025
212-866-0009 or 212-666-3026

16 de agosto de 2021

Hola familias

Nos complace anunciar la preinscripción para nuestro programa extracurricular para jóvenes en los grados K-8. Esperamos que usted y su familia se mantengan a salvo durante estos tiempos sin precedentes. Se espera que Goddard Riverside abra completamente en persona en el Complejo Joan of Arc según las pautas del Departamento de Educación / Departamento de Salud.

Continuamos con nuestra dedicación para involucrar a nuestros jóvenes en actividades de calidad que les brinden la oportunidad de aprender, crecer y explorar nuevas ideas. Le damos la bienvenida nuevamente.

* Estamos a la espera de información sobre restricciones con respecto a los jóvenes que asisten a escuelas distintas de nuestras escuelas anfitrionas: PS333 (Manhattan School for Children), MS258 (Community Action School) y MS 256 (Lafayette Academy).

Una vez que el programa comience, está programado para comenzar el lunes 20 de septiembre (sujeto a cambios según la escuela pública). Los participantes se agruparán por grado y participarán en todas las actividades juntos. El uso de máscaras será obligatorio para todos los jóvenes y el personal, habrá desinfectante de manos disponible y practicaremos el distanciamiento físico. Durante la salida, los niños que se les permita ir a casa serán despedidos en la entrada principal. Para los niños que necesiten ser recogidos, se le traerá a su hijo en la entrada principal una vez que nos hayan informado que ha llegado. Su hijo solo puede asistir en persona los días que asiste a la escuela.

Puede registrar a su hijo usando los formularios adjuntos o puede descargarlos del sitio web www.goddard.org y enviarlos a agomez @ gomez @ goddard.org o rbaptiste@goddard.org. Envíe los formularios completos con los documentos de respaldo lo antes posible.

• Para los participantes de nuestro campamento de verano: envíe el formulario de actualización de información extracurricular (adjunto)

• Para todos los demás, complete la Solicitud de admisión universal para participantes (formulario en papel o en línea en https://discoverdycd.dycdconnect.nyc/home)

• Para todos los formularios de Yearly Medial (no pueden tener más de 1 año) a menos que se presenten durante el verano

• Comprobante de ingresos (por ejemplo, copias del formulario W-2 de 2020, 2 recibos de pago, carta de presupuesto o tarjeta de beneficios)

• Formulario de elegibilidad de ingresos

Si tiene alguna pregunta o inquietud, no dude en comunicarse con nosotros al 212-866-0009 o agomez@goddard.org o rbaptiste@goddard.org.

Gracias por su cooperación y apoyo pasados, presentes y futuros. Espero verlos a todos muy pronto.

Atentamente,

El equipo de personal de Beacon

Goddard Riverside @ MS258

___ES
___MS
___HS
___A
Activity _____
Activity _____

discover Opportunities and Services Near You DYCD

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:

NYC Department of Youth & Community Development | COMPASS NYC — The Comprehensive Afterschool System of New York City | SONYC | Beacon Centers of New York City | Cornerstone

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

For the purposes of this application, applicant refers to the person applying to receive services. Select one:

☐ I am completing this application for myself ☐ I am a parent or guardian completing this application for my child

☐ I am a relative/non-relative, completing this application on behalf of the applicant

Applicant's First Name:	**Applicant's Last Name:**	**MI:**

Applicant's Date of Birth (MM/DD/YEAR):	**Applicant's Primary Address** (*Number and Street*):

Applicant's Apt. Number:	**Applicant's City**:	**Zip Code:**

Applicant's Sex at Birth (Select One):

☐ Female
☐ Male
☐ X (not female or male)
☐ Not sure

Applicant's Race (Select all that Apply):

☐ American Indian and Alaskan Native
☐ Asian
☐ Black or African-American
☐ Middle Eastern/North African
☐ Native Hawaiian and Other Pacific Islander
☐ White or Caucasian
☐ Other _____

Applicant's Ethnicity (Select One):

☐ Hispanic or Latinx
☐ Not Hispanic or Latinx

☐ **Applicant lives in a NYCHA Development (please provide name)** _____

Department of Youth & Community Development | COMPASS NYC | SONYC | Beacon Centers of New York City | Cornerstone

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: ☐ 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:** ☐ Emergency contact is parent/guardian of participant

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

☐ Home _____ ☐ Cell _____ ☐ No Email

☐ Work ☐ Email

Address: ☐ Same as Applicant	**City:**	**State:**	**Zip Code:**

2

Emergency Contact #2 Name: | **Relationship to Participant:** ☐ Emergency contact is parent/guardian of participant

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

☐ Home _____ ☐ Cell _____ ☐ No Email

☐ Work ☐ Email

Address: ☐ 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):

☐ 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 _____

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

Does the applicant have health insurance? (Select One):

☐ Yes ☐ No

☐ Decline to Answer

***If yes,* what kind of health insurance does the applicant have?**
(Check all that Apply):

☐ Medicaid
☐ Medicare
☐ State Children's Health Insurance Program
☐ Employment-Based
☐ Direct-Purchase
☐ State Children's Health Insurance for Adults
☐ Military Health Care
☐ 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):

☐ English	☐ Albanian	☐ Arabic
☐ Bengali	☐ Chinese*	☐ French
☐ Fulani	☐ German	☐ Gujarati
☐ Haitian Creole	☐ Hebrew	☐ Hindi
☐ Hungarian	☐ Italian	☐ Japanese
☐ Korean	☐ Kru, Ibo, or Yoruba	☐ Mande
☐ Punjabi	☐ Persian	☐ Polish
☐ Portuguese	☐ Romanian	☐ Russian
☐ Spanish	☐ Tagalog	☐ Turkish
☐ Urdu	☐ Vietnamese	☐ Yiddish

☐ Other: _____

**including Cantonese and Mandarin*

Other Languages Spoken by Applicant (Select all that Apply):

☐ English	☐ Albanian	☐ Arabic
☐ Bengali	☐ Chinese	☐ French
☐ Fulani	☐ German	☐ Gujarati
☐ Haitian Creole	☐ Hebrew	☐ Hindi
☐ Hungarian	☐ Italian	☐ Japanese
☐ Korean	☐ Kru, Ibo, or Yoruba	☐ Mande
☐ Punjabi	☐ Persian	☐ Polish
☐ Portuguese	☐ Romanian	☐ Russian
☐ Spanish	☐ Tagalog	☐ Turkish
☐ Urdu	☐ Vietnamese	☐ 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?	☐ Yes	☐ No	
Offender/Justice Involved?	☐ Yes	☐ No	
Foster Care Participant?	☐ Yes	☐ No	
Runaway Youth?	☐ Yes	☐ No	
Veteran?	☐ Yes	☐ No	
Active Military Personnel?	☐ Yes	☐ 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):

- ☐ Single Parent - Female
- ☐ Single Parent - Male
- ☐ Single Person - No children
- ☐ Non-related adults with children
- ☐ Two Adults – No Children
- ☐ Two Parent Household
- ☐ Multigenerational Household
- ☐ Other: _____

Applicant's Housing Type (Select One):

- ☐ Own
- ☐ Rent
- ☐ NYCHA
- ☐ Shelter
- ☐ Homeless
- ☐ Other Permanent Housing
- ☐ Other: _____

Applicant's Household Size (Select One):

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

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

- ☐ $0
- ☐ $1 to $12,060
- ☐ $12,061 to $16,240
- ☐ $16,241 to $20,420
- ☐ $20,421 to $24,600
- ☐ $24,601 to $28,780
- ☐ $28,781 to $32,960
- ☐ $32,961 to $37,140
- ☐ $37,141 to $41,320
- ☐ $41,321 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

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

- ☐ Employment Wages
- ☐ Childcare Voucher
- ☐ Housing Choice Voucher
- ☐ Permanent Supportive Housing
- ☐ Retirement Income from Social Security
- ☐ Temporary Assistance for Needy Families (TANF)
- ☐ WIC
- ☐ Affordable Care Act Subsidy
- ☐ Earned Income Tax Credit (EITC)
- ☐ HUD-VASH
- ☐ Private Disability Insurance
- ☐ Social Security Disability Income (SSDI)
- ☐ Unemployment Insurance
- ☐ Worker's Compensation
- ☐ Alimony or other Spousal Support
- ☐ Employment Tax Credit
- ☐ LIEHEAP
- ☐ Public Housing
- ☐ Supplemental Security Income (SSI)
- ☐ VA Non-Service Connected Disability Pension
- ☐ Other: _____
- ☐ Child Support
- ☐ General Assistance
- ☐ Pension
- ☐ Safety Net/Home Relief
- ☐ Supplemental Nutrition Assistance Program (SNAP)
- ☐ VA Service-Connected Disability Compensation
- ☐ Decline to Answer

NYC Department of Youth & Community Development | COMPASS NYC | SONYC | Beacon Centers of New York City | Cornerstone

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.

- NYC Department of Education
- NYC Department of Health and Mental Hygiene
- NYS Department of Health
- NYC Department of Youth and Community Development
- NYC Health and Hospitals Corporation
- Contracted Service Providers for COVID-19 Testing

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

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: Goddard Riverside Community Center | 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
Psychosocial Development	☐	☐
Language	☐	☐
Behavioral	☐	☐
HEENT	☐	☐
Dental	☐	☐
Neck	☐	☐
Lymph nodes	☐	☐
Lungs	☐	☐
Cardiovascular	☐	☐
Abdomen	☐	☐
Genitourinary	☐	☐
Extremities	☐	☐
Skin	☐	☐
Neurological	☐	☐
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

DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Tdap	___/___/___	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	MMR	___/___/___	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Varicella	___/___/___	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Mening ACWY	___/___/___	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Hep A	___/___/___	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Rotavirus	___/___/___	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Mening B	___/___/___	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Other _____	___/___/___	___/___/___

IgG Titers	Date
Hepatitis B	___/___/___
Measles	___/___/___
Mumps	___/___/___
Rubella	___/___/___
Varicella	___/___/___
Polio 1	___/___/___
Polio 2	___/___/___
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 ___/___/___

DOHMH ONLY PRACTITIONER I.D.

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

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

Comments:

Facility Name | National Provider Identifier (NPI)

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

REVIEWER:

Address | City | State | Zip

Telephone | Fax | Email

FORM ID#