





# Parent / Guardian Information

59. Last Name

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60. First Name

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61. Middle

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62. Street Address (number and street)

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63. Apt #

--	--	--	--	--

64. Zip Code

--	--	--	--	--	--

65. Borough Code

1. Bronx 2. Brooklyn 3. Manhattan 4. Queens 5. Staten Island

66. Birth Date:

Month

Day

Year

67. Home Phone Number

(Area code)

68. Work Phone

(Area code)

69. Cell / Pager Number

70. Email Address:

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71. Ethnicity

1. American Indian

2. Asian (Non-Hispanic)

3. Black (Non-Hispanic)

4. Hispanic/Latino

5. Pacific Islander

6. White (Non - Hispanic)

7. Other

72. Relationship to applicant

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73. Primary Language Spoken

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74. English Proficient

Yes

No

## Additional Parent / Guardian Information

75. Last Name

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76. First Name

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77. Middle

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78. Street Address (number and street)

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Month

Day

Year

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(Area code)

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89. Primary Language Spoken

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90. English Proficient

Yes

No

# Health Information

**91. Please check any box that applies to your child:**

	YES	NO
Allergies to food (please specify):	<input type="checkbox"/>	<input type="checkbox"/>
Allergies to medicine (please specify) :	<input type="checkbox"/>	<input type="checkbox"/>
Allergies Other (please specify):	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral/Emotional issues	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Corrective Device (glasses, hearing aid, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Individualized Education Plan	<input type="checkbox"/>	<input type="checkbox"/>
Physical Disabilities	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify):	<input type="checkbox"/>	<input type="checkbox"/>

Children who have special health care needs are those who have chronic physical, developmental, behavioral, or emotional conditions expected to last 12 months or more and who also require health and related services of a type beyond that are required by children generally. If your child does have special health care needs please discuss these with your child care provider.

Please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**92.** Does your child have special health care needs that require treatment and/or medication?  YES  NO

Please explain: \_\_\_\_\_  
 \_\_\_\_\_

**93.** Does your child take medication for any condition or illness?  YES  NO

Please explain: \_\_\_\_\_  
 \_\_\_\_\_

**94.** Are there any activities your child cannot participate in?  YES  NO (if yes, please specify)

Please explain: \_\_\_\_\_  
 \_\_\_\_\_

**CERTIFICATION STATEMENT**

I, the undersigned, certify that all information on this form is true and correct. I understand that my statements are subject to verification. I agree and accept that I will abide by all applicable rules and regulations of this program. I consent to the enrollment and participation of the child listed above in this program.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Intake Officer Signature \_\_\_\_\_ Date \_\_\_\_\_

**DYCD EMERGENCY MEDICAL CARE** (To be completed by the parent or guardian)

**Student's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**1. If my child requires emergency medical care and I cannot be reached, I give my consent to the above after-school program to obtain the necessary medical care for my child. I agree to pay all of the costs associated with the emergency medical care that my child receives. I understand that every effort will be made to contact me before and after medical care is provided.**

**2. Following emergency medical care, my child may be released to the following people:**

Name:	_____	Relationship to Child:	_____
Address:	_____	Employer:	_____
Home Phone:	_____	Work Phone:	_____

Name:	_____	Relationship to Child:	_____
Address:	_____	Employer:	_____
Home Phone:	_____	Work Phone:	_____

Name:	_____	Relationship to Child:	_____
Address:	_____	Employer:	_____
Home Phone:	_____	Work Phone:	_____

**3. Health/Insurance Information:**

Student's Doctor:	_____	Insurance Company:	_____
Phone:	_____	Policy Holder's ID:	_____
Allergies:	_____	Religious Preference: (optional)	_____
Last Tetanus:	_____	Medication(s) being taken:	_____
Address (student's doctor):	_____		

**Additional Comments:** \_\_\_\_\_

**4. I understand that this consent will be in effect as of the date of my signing this form and will continue as long as my child is enrolled in this after-school program.**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

See INSTRUCTIONS on reverse.

**DAY CARE CENTER NAME:** \_\_\_\_\_

Print the name of the child(ren) enrolled in Day Care:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**DIRECTIONS:**

**Complete SECTION A if your household:**

1. Receives Temporary Assistance to Needy Families (TANF)
2. Receives Food Stamps
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR)
4. Currently has a foster child enrolled in day care

**Complete SECTION B if Section A does not apply:**

Sign, date and indicate the Social Security number of the adult signing the certification and return the completed form to the day care center.

SECTION A	SECTION B															
<p>TANF Number _____</p> <p>Food Stamp Case Number _____</p> <p>FDPIR Number _____</p> <p>Foster Child's Name _____</p> <p>Foster Child's Personal Monthly Income \$ _____</p> <p><b>An adult household member must sign the application before it can be approved.</b> After reading the following statement and the statement on the back, sign below.</p> <p>I certify that the above information is true and correct and that all income is reported. I understand this information is being given for the receipt of Federal funds, that officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.</p> <p>Signature: _____</p> <p>Date: _____</p>	<p>List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received <b>last month</b> in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, welfare payments, child support and any other sources of income.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;">Name of Household Members</th> <th style="width: 30%;">Monthly Gross Income</th> </tr> </thead> <tbody> <tr><td>1. _____</td><td>\$ _____</td></tr> <tr><td>2. _____</td><td>\$ _____</td></tr> <tr><td>3. _____</td><td>\$ _____</td></tr> <tr><td>4. _____</td><td>\$ _____</td></tr> <tr><td>5. _____</td><td>\$ _____</td></tr> <tr><td>6. _____</td><td>\$ _____</td></tr> </tbody> </table> <p><b>An adult household member must sign the application before it can be approved.</b> After reading the following statement and the statement on the back, sign below.</p> <p>I certify that the above information is true and correct and that all income is reported. I understand this information is being given for the receipt of Federal funds, that officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.</p> <p>Signature: _____</p> <p>Print Name: _____</p> <p>SS# _____ Date: _____</p>		Name of Household Members	Monthly Gross Income	1. _____	\$ _____	2. _____	\$ _____	3. _____	\$ _____	4. _____	\$ _____	5. _____	\$ _____	6. _____	\$ _____
Name of Household Members	Monthly Gross Income															
1. _____	\$ _____															
2. _____	\$ _____															
3. _____	\$ _____															
4. _____	\$ _____															
5. _____	\$ _____															
6. _____	\$ _____															
<b>FOR SPONSOR USE ONLY</b>																
<p>Sponsor Agreement Number _____</p> <p>Total Household Members _____</p> <p>Total Income \$ _____</p> <p>Free _____ Reduced _____ Paid _____</p> <p>Signature of Determining Official _____</p> <p>Date Determined ____ / ____ / ____</p>																

## **Section 9**

Unless you list the child's food stamp, FDPIR or TANF case number or are applying for a foster child, Section 9 of the National School Lunch Act requires that you include the social security number of the household member signing the application or indicate that the household member signing the application does not have a social security number. You do not have to list a social security number, but if a social security number is not listed or an indication is not made that the adult household member signing the application does not have a social security number, we cannot approve the application. The social security number may be used to identify the household member in verifying the correctness of the information stated on the application. This may include program reviews, audits and investigations and may include contacting employers to determine income, contacting a food stamp, FDPIR or TANF office to determine current certification for food stamps, FDPIR or TANF benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims or legal actions if incorrect information is reported.

### **Definition of Income**

*Income* means income before deductions for income taxes, social security taxes, insurance premiums, charitable contributions, and bonds, etc. It includes the following: (1) monetary compensation for services, including wages, salary, commissions or fees; (2) net income from non-farm self-employment; (3) net income from farm self-employment; (4) social security payments; (5) dividends or interest on savings or bonds, income from estates or trusts or net rental income; (6) public assistance or welfare payments; (7) unemployment compensation; (8) government civilian employee or military retirement, or pensions or veteran's payments; (9) private pensions or annuities; (10) alimony or child support payments; (11) regular contributions from persons not living in the household; (12) net royalties; (13) military benefits received in cash, such as housing allowance; and (14) any other cash income.

### **Definition of Household**

Household means *family* as defined in Section 226.2. *Family* means a group of related or non-related individuals who are not residents of an institution or boarding house, but who are living as one economic unit.

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## **INSTRUCTIONS FOR COMPLETING DOH-3688**

### **Instructions for Parents or Guardians:**

Write in the name of the day care center in the space provided.

Print the name of each child in your household who attends this day care center.

**Section A:** If your household receives Temporary Assistance for Needy Families (TANF) or Food Stamps or participates in the Food Distribution Program on Indian Reservations (FDPIR), complete Section A only. Write down the TANF, FS or FDPIR number (do not use your ACD or DSS child care subsidy number) and sign and date the form and return it to the day care center.

**Foster children:** If your household includes a foster child who is in day care, complete Section A only. Write in the foster child's name and any income that the child receives from social services for his or her personal use. Write in 0 if the foster child does not receive any income. A separate application must be completed for each foster child. The foster parent or an official who represents the child must sign and date the form and then return it to the day care center.

**Section B:** Write in the names of all the people living in your household, even if they do not have any income. Include yourself and all other adults and children in the household, including unrelated people. Do not include the children in day care, who are listed at the top of the form.

Enter the amount of income each person received **last month**, before taxes or anything else was taken out. Refer to the Definition of Income and the Definition of Household above. If any amount last month was more or less than the usual, write in that person's usual income. The signature and social security number of the adult signing the certification is required. If you do not have a social security number, write *none*.

### **Instructions for Centers and Sponsors**

**The For Sponsor Use Only section is to be completed, signed and dated by day care center or sponsor staff.**

The sponsor/center representative must review the income eligibility application and ensure that it is completed as indicated in the instructions above. Then indicate the following:

**The sponsor agreement number.**

**Total household members** – This item does not have to be completed if the parent completed Section A. Add those indicated in Section B (if completed) to the children enrolled in day care.

**Total Income** – This item does not need to be completed if the parent completed Section A. Indicate the total monthly income as calculated from Section B. If the parent chooses not to disclose income, the application must be categorized as *paid*.

**Free, Reduced or Paid** – Compare the total household income and the total number of household members with the current year's Income Eligibility Guidelines (CACFP-3687) to determine if the household should be categorized as **Free, Reduced** or **Paid**. Use the appropriate column on the CACFP-3687 to categorize their income. For example, if the parent indicated biweekly income, multiply this amount by 26 to determine yearly income.

Incomplete applications (missing signatures, income information, social security numbers, TANF FDPIR or Food Stamp numbers) are categorized in the paid category.

**The income eligibility application is valid for one calendar year only.**

# CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please  
Print Clearly  
Press Hard

STUDENT ID NUMBER  
OSIS

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

## TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name	First Name	Middle Name	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (Month/Day/Year) ____/____/____
Child's Address			Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	Race (Check ALL that apply) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other
City/Borough	State	Zip Code	School/Center/Camp Name	District Number
Health insurance (including Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Parent/Guardian Last Name	First Name	Phone Numbers Home _____ Cell _____ Work _____	

## TO BE COMPLETED BY HEALTH CARE PROVIDER *If "yes" to any item, please explain (attach addendum, if needed)*

<b>Birth history (age 0-6 yrs)</b> <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____ <b>Allergies</b> <input type="checkbox"/> None <input type="checkbox"/> Epi pen prescribed <input type="checkbox"/> Drugs (list) _____ <input type="checkbox"/> Foods (list) _____ <input type="checkbox"/> Other (list) _____	<b>Does the child/adolescent have a past or present medical history of the following?</b> <i>If persistent, check all current medication(s):</i> <input type="checkbox"/> Inhaled corticosteroid <input type="checkbox"/> Other controller <input type="checkbox"/> Quick relief med <input type="checkbox"/> Oral steroid <input type="checkbox"/> None <input type="checkbox"/> Attention Deficit Hyperactivity Disorder <input type="checkbox"/> Orthopedic injury/disability <input type="checkbox"/> Chronic or recurrent otitis media <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Other (specify) _____	<b>Medications (attach MAF if in-school medication needed)</b> <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____ _____ <b>Dietary Restrictions</b> <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____ _____
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*Explain all checked items above or on addendum*

<b>PHYSICAL EXAMINATION</b> Height _____ cm (____ %ile) Weight _____ kg (____ %ile) BMI _____ kg/m <sup>2</sup> (____ %ile) Head Circumference (age ≤2 yrs) _____ cm (____ %ile) Blood Pressure (age ≥3 yrs) _____ / _____	<b>General Appearance:</b> <table border="0"> <tr> <td><i>Nl Abnl</i></td><td><input type="checkbox"/> HEENT</td><td><i>Nl Abnl</i></td><td><input type="checkbox"/> Lymph nodes</td><td><i>Nl Abnl</i></td><td><input type="checkbox"/> Abdomen</td><td><i>Nl Abnl</i></td><td><input type="checkbox"/> Skin</td><td><i>Nl Abnl</i></td><td><input type="checkbox"/> Psychosocial Development</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/> DENTAL</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Lungs</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Genitourinary</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Neurological</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Language</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/> Neck</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Cardiovascular</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Extremities</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Back/spine</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Behavioral</td> </tr> </table> <b>Describe abnormalities:</b> _____ _____	<i>Nl Abnl</i>	<input type="checkbox"/> HEENT	<i>Nl Abnl</i>	<input type="checkbox"/> Lymph nodes	<i>Nl Abnl</i>	<input type="checkbox"/> Abdomen	<i>Nl Abnl</i>	<input type="checkbox"/> Skin	<i>Nl Abnl</i>	<input type="checkbox"/> Psychosocial Development	<input type="checkbox"/>	<input type="checkbox"/> DENTAL	<input type="checkbox"/>	<input type="checkbox"/> Lungs	<input type="checkbox"/>	<input type="checkbox"/> Genitourinary	<input type="checkbox"/>	<input type="checkbox"/> Neurological	<input type="checkbox"/>	<input type="checkbox"/> Language	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/> Extremities	<input type="checkbox"/>	<input type="checkbox"/> Back/spine	<input type="checkbox"/>	<input type="checkbox"/> Behavioral
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<b>DEVELOPMENTAL (age 0-6 yrs)</b> <input type="checkbox"/> Within normal limits If delay suspected, specify below <input type="checkbox"/> Cognitive (e.g., play skills) _____ <input type="checkbox"/> Communication/Language _____ <input type="checkbox"/> Social/Emotional _____ <input type="checkbox"/> Adaptive/Self-Help _____ <input type="checkbox"/> Motor _____	<b>SCREENING TESTS</b> <table border="1"> <thead> <tr> <th></th> <th>Date Done</th> <th>Results</th> </tr> </thead> <tbody> <tr> <td><b>Blood Lead Level (BLL)</b> (required at age 1 yr and 2 yrs and for those at risk)</td> <td>____/____/____</td> <td>_____ µg/dL</td> </tr> <tr> <td><b>Lead Risk Assessment</b> (annually, age 6 mo-6 yrs)</td> <td>____/____/____</td> <td><input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk</td> </tr> <tr> <td><b>Hearing</b> <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE</td> <td>____/____/____</td> <td><input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</td> </tr> <tr> <td><b>Hemoglobin or Hematocrit (age 9-12 mo)</b></td> <td>____/____/____</td> <td>_____ g/dL _____ %</td> </tr> </tbody> </table>		Date Done	Results	<b>Blood Lead Level (BLL)</b> (required at age 1 yr and 2 yrs and for those at risk)	____/____/____	_____ µg/dL	<b>Lead Risk Assessment</b> (annually, age 6 mo-6 yrs)	____/____/____	<input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk	<b>Hearing</b> <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE	____/____/____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<b>Hemoglobin or Hematocrit (age 9-12 mo)</b>	____/____/____	_____ g/dL _____ %	<b>Tuberculosis</b> <i>Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school</i> PPD/Mantoux placed _____/____/____ Induration _____ mm PPD/Mantoux read _____/____/____ <input type="checkbox"/> Neg <input type="checkbox"/> Pos Interferon Test _____/____/____ <input type="checkbox"/> Neg <input type="checkbox"/> Pos Chest x-ray (if PPD or Interferon positive) _____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Not Indicated <input type="checkbox"/> Abnl <b>Vision</b> <i>(required for new school entrants and children age 4-7 yrs)</i> _____/____/____ Acuity Right _____ / _____ _____/____/____ Left _____ / _____ <input type="checkbox"/> with glasses Strabismus <input type="checkbox"/> No <input type="checkbox"/> Yes
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<b>IMMUNIZATIONS - DATES</b> CIR Number of Child _____ Hep B _____/____/____ Rotavirus _____/____/____ DTP/DTaP/DT _____/____/____ Hib _____/____/____ PCV _____/____/____ Polio _____/____/____	Influenza _____/____/____ MMR _____/____/____ Varicella _____/____/____ Td _____/____/____ Tdap _____/____/____ Hep A _____/____/____ Meningococcal _____/____/____ HPV _____/____/____ Other, Specify: _____; _____; _____
--	--

<b>RECOMMENDATIONS</b> <input type="checkbox"/> Full physical activity <input type="checkbox"/> Full diet <input type="checkbox"/> Restrictions (specify) _____ <b>Follow-up Needed</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____ <b>Referral(s):</b> <input type="checkbox"/> None <input type="checkbox"/> Early Intervention <input type="checkbox"/> Special Education <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____	<b>ASSESSMENT</b> <input type="checkbox"/> Well Child (V20.2) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-9 Code _____ _____ _____
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Health Care Provider Signature	Date ____/____/____	DOHMH PROVIDER ONLY I.D. _____
Health Care Provider Name and Degree (print)	Provider License No. and State	TYPE OF EXAM: <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s)
Facility Name	National Provider Identifier (NPI)	Comments
Address	City	Date Reviewed: ____/____/____
Telephone (____) _____-____	Fax (____) _____-____	I.D. NUMBER _____
		REVIEWER: _____

CHILDREN'S ARTS AND SCIENCE WORKSHOPS, INC.

**Parent Consent to Participate in the Evaluation of the  
Out of School Time Program**

Dear Parent,

Your child, \_\_\_\_\_, is enrolled in the after school program at \_\_\_\_\_, which is supported by Department of Youth and Community Development (DYCD). In order to monitor the effectiveness of the OST program and ensure its future success, DYCD is conducting an ongoing evaluation. It is the intention of the evaluation to learn how these services help students and how they can be improved in order to meet the grant requirements.

Specifically we ask permission from parents to:

- Contact their children's school and obtain records showing their progress, including information about enrollment, grades, citywide and statewide test scores, and attendance.
- Talk to teachers and after-school staff about children's progress and participation in the program, and review program records on participation in the program.
- Survey and/or interview parents and children about the program and its effects.

**Any information we collect will be used only to assess the program and will not be made public. Participating in the evaluation will not affect your child in school, in the program, or in any other way. We will not use your name or your child's name in any report.** At the end of the evaluation, we will destroy all records that include personal information. Participation in the study is completely voluntary and participants may withdraw at any time with no consequences.

Please select one of the options below and return this form to the program coordinator/director.

*YES, I GIVE PERMISSION FOR MY CHILD TO PARTICIPATE. I have read the above information and I give permission for my child to participate in the evaluation of the program. I also consent for DYCD to obtain my child's records and to interview program and school staff for evaluation purposes.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

*NO, I DO NOT WANT MY CHILD TO PARTICIPATE. I have read the above information and I DO NOT give permission for my child to participate in the evaluation of the program.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If you have any questions about the evaluation contact the site coordinator.

## PARENT/GUARDIAN RELEASE



I hereby agree to release, indemnify and hold harmless Children's Arts & Science Workshop, Inc., their agents, employees and subdivision(s) from any and all liability, damages or cost, including attorney's fees, for personal or property damages which arise out of, or are associated with or result from an accident or injury which involves \_\_\_\_\_ (child's name) and which are related to or occur while on the program's property or on associated program trips.

I understand that my child is responsible for his/her behavior at all times. If my child becomes involved in behavior which is unacceptable or presents a danger to himself/herself or to other students, appropriate steps will be taken to protect all students. Should the child become uncooperative, the child may be excluded from the activity.

**Legal requirements:** All students shall observe and comply with all laws, codes, rules and regulations of the state, federal, municipal and local government, departments, commissions and boards, (including, but not limited to applicable fire and safety codes) which may apply to their use and occupancy of any premises visited while accompanied by agents, employees and subdivision(s) of Children's Arts & Science Workshop, Inc.

**ACTS OF GOD:** In the event of an act of war (declared or otherwise), strike, work stoppage, hurricane, earthquake, other natural disaster, or a reason beyond the control of Children's Arts & Science Workshop, Inc., their agents, employees and subdivision(s) (each such activity is referred to as an "Act of God,") and the student event is canceled or disrupted by reasons of such Act of God, Children's Art's & Science Workshops, Inc., their agents, employees and subdivision(s) shall not be responsible or liable for any loss or damage of any kind as a result of the Act of God.

I hereby acknowledge that I have read, understand and agree to all terms and information contained on this form.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Children's Arts & Science Workshops, Inc. \_\_\_\_\_



## PHOTO/VIDEO/INTERVIEW CONSENT

(To be completed by the parent or guardian)

I certify that I am the parent or legal guardian of \_\_\_\_\_, whose date  
of birth is \_\_\_\_\_. name of child  
month/day/year

I understand that this after-school program features special events both in-school and away from school. Media representatives, newspaper and television reporters, photographers, and public-relations personnel may be present at these special events to record them. In some cases they may interview and/or photograph children who participate in these events. These photographs, videos, and interviews will only be used to promote this after-school program.

**I give permission for my child to be photographed or otherwise recorded during after-school events and activities, and for any and all such photographs to be displayed by Children's Arts & Science Workshops, Inc. \_\_\_\_\_ or The Department of Youth and Community Development in any medium (books, newsletters, web sites, etc.), whether now or hereafter known or developed.**

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SIGNATURE OF PARENT OR GUARDIAN

DATE

If you do not wish for your child to participate in the activities described above, please review this section of this form.

**I DO NOT** give permission for my child to be photographed or otherwise recorded during after-school events and activities. As a result, my child may not be able to participate in these events and activities.

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SIGNATURE OF PARENT OR GUARDIAN

DATE



CHILDREN'S ARTS AND SCIENCE WORKSHOPS, INC.

4271 Broadway (2<sup>nd</sup> FL)

NY, NY 10033

Tel. 212.923.7766 • Fax 212.795.5901

**REQUIRED DOCUMENTATION FOR ENROLLMENT**

- Copy of Physical Examination (Physical expires one year after date of examination)
- Copy of Immunization Card
- Copy of Health Insurance Card or Information
- Copy of Birth Certificate or passport
- 2 Recent Pictures (2x2 passport size)
- Proof of Address (ConEdison bill, phone bill, etc.)

**DOCUMENTOS REQUERIDO PARA INSCRIPCIÓN**

- Copia de examen fisico
- Copia de la carta de inmunizacion
- Copia de seguro medico
- Copia de acta de nacimiento o pasaporte
- 2 fotos (2 por 2)
- Prueba de direccion