



Cambridge Youth Programs
Afterschool and Summer Program Application Packet
Youth Information

Last Name	First Name	Date of Birth	Age
Home Address		City, Zip Code	
		Email Address	
Eye Color	Hair Color	Skin Color	Height
		Weight	Identifying Marks

Racial/Ethnic Background:
 American Indian Asian Black Hispanic/Latino White Other: _____

Gender: Male Female Primary Language Spoken at Home: _____

Please Check Each Session Desired

Afterschool Session One: Tuesday, September 6, 2011 – Friday, January 13, 2012 _____

Afterschool Session Two: Tuesday, January 17, 2012 – Friday, June 15, 2012 _____

The registration fee for each afterschool session is \$50.00
(Frisoli and Gately Middle School Programs are free)

Please make check or money order payable to "Cambridge Youth Programs"
(There is a separate fee and registration form for school vacation weeks and summer programs)

Parent/Guardian Information

Guardian #1 Name	Guardian #2 Name
Relation to Child	Relation to Child
Home Address	Home Address
Home Telephone Number	Home Telephone Number
Cell Phone Number	Cell Phone Number
@	@
E-Mail Address	E-Mail Address
Place of Employment	Place of Employment
Work Telephone #	Work Telephone #

School Information (as of September 2011)

Name of School: _____ Grade: _____ Teacher's Name: _____

I certify that documentation of physical examination and immunizations in accordance with public school health requirements, and lead poisoning screening in accordance with public health requirements are on file at my child's school. **Parent/Guardian Initials:** _____

Parent/Guardian Signature	Date
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For Office Use Only

Original Date of Admission into Program: _____

Youth Center Information (Please check the Youth Center your child will attend)

- Area IV Youth Center** {ages 9 to 13} 243 Harvard Street (617) 349-6262
- Frisoli Youth Center** {ages 9 to 13} 61 Willow Street (617) 349-6312
 - Frisoli Pre-teen Program
 - Frisoli Middle School Partnership Program {grades 7 & 8 only}
- Gately Youth Center** {ages 9 to 13} 70R Rindge Avenue (617) 349-6277
 - Gately Pre-teen Program
 - Gately Middle School Partnership Program {grades 6, 7 & 8 only}
- Russell Youth Center** {ages 9 to 13} 680 Huron Avenue (617) 349-6314

Please specify when your child will attend the Youth Center. If your child does not show up on a day that he/she is scheduled, a staff person will call you. If you know in advance that your child will be absent, please notify the center as early as possible. (Please note, afterschool hours are 2:00 pm to 6:00 pm)

	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival Time:					
Departure Time:					

Transportation Plan and Authorization

My child will **arrive** at the program by:

- _____ Unsupervised Walk
- _____ Supervised Walk (who: _____)
- _____ School Bus Drop Off
- _____ Parent/Guardian Drop Off
- _____ Other (Describe: _____)

Parent/Guardian Initials: _____

My child will **depart** at the program by:

- _____ Unsupervised Walk
- _____ Supervised Walk (who: _____)
- _____ Parent/Guardian Pick Up
- _____ Other (Describe: _____)

Parent/Guardian Initials: _____

The following individuals may pick up my child from the program. If someone other than these people picks up my child, I will notify staff in writing in advance.

1. Name: _____ Relationship: _____
Address: _____ Phone Number: _____
2. Name: _____ Relationship: _____
Address: _____ Phone Number: _____
3. Name: _____ Relationship: _____
Address: _____ Phone Number: _____

I hereby give my child permission to participate in all Youth Center programs, activities and trips. I understand that the activities may include team sports, field trips, and workshops on various topics such as career awareness, violence prevention, alcohol/drug abuse, and other issues pertinent to pre-adolescents.

Media Release

I _____ **do** _____ **do not** give permission to the City of Cambridge and the Cambridge Youth Programs to use photographic and video reproductions of my child for publicity purposes.

Parent/Guardian Signature

Date

First Aid and Emergency Medical Care Consent

Child's Name

Date of Birth

I authorize Cambridge Youth Programs staff who are trained in the basics of First Aid and/or CPR to give my child First Aid/CPR when appropriate. I also allow the staff of CYP to assist my child in applying sunscreen.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and/or to _____, and to secure necessary medical treatment for my child.

Instructions to reach parent/guardian:

- | | |
|------------------|-------------------------------------------------------------|
| 1. _____
Name | home phone: _____
work phone: _____
cell phone: _____ |
| 2. _____
Name | home phone: _____
work phone: _____
cell phone: _____ |

Child's Pediatrician or Source of Health Care:

_____ phone: _____
Name and Address

Child's Allergies*: _____

Symptoms of Allergic Reaction: _____

Chronic Health Conditions/Medications*: _____

(*Please Note: If your child is on **any** medication {prescription, including inhalers, and over the counter} we must have a signed Medication Consent form on file for your child. The consent form must contain the signatures of the parent/guardian *and* the prescribing physician. **Please see page 8.**)

Health Insurance Company: _____ **Policy #:** _____

Emergency Contacts (in order to be contacted if guardians are unable to be reached):

- | | |
|-------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|
| 1. Name: _____
Relationship to child: _____
Do you give permission for your child to be released to this person? _____ yes _____ no | address: _____
phone: _____ |
| 2. Name: _____
Relationship to child: _____
Do you give permission for your child to be released to this person? _____ yes _____ no | address: _____
phone: _____ |
| 3. Name: _____
Relationship to child: _____
Do you give permission for your child to be released to this person? _____ yes _____ no | address: _____
phone: _____ |

Parent/Guardian Signature

Date

Off-Site Activities Permission Form

Child's Name

Date of Birth

I, _____, give permission for my child to participate
(Parent/Guardian's Name)

in all of the regularly scheduled on-going activities located at the following off-site facilities:

Area IV Youth Center, Frisoli Youth Center, Gately Youth Center, Moore Youth Center,

Russell Youth Center, Boys & Girls Club, YMCA, Cambridge Community

Center, parks, playgrounds and other destinations within a one mile radius of the "home"

Youth Center

The program will provide in writing a list of scheduled activities.

Parent/Guardian Signature

Date

Family Information Questionnaire

This form provides staff with a brief picture of your child and his/her family. The following information is strictly confidential and will only be used to help CYP staff understand and learn about your child. Any further information you feel might help the staff members make your child more comfortable at the program can be added on a separate sheet.

Child's Name: _____ Nickname: _____

1. Can your child speak and understand English? _____

2. How many children are in your family? _____

Name: _____ Gender: _____ Date of Birth: _____

3. Others in family who live in the same house:

Name: _____ Gender: _____ Relationship: _____

Name: _____ Gender: _____ Relationship: _____

4. What do you hope your child gains from this program? _____

5. With which agencies, services or partners do you work to support your child's development? _____

6. Does your child have any special needs? (health, physical, emotional) Yes ___ No ___

If yes, what type? _____

7. Have there been any major changes in your family routine during the past year? A new baby? Moving? Accident or injury to your child or other family member? _____

8. How does your child usually respond to a new experience? Shy? Assertive? Please describe:

9. What do you find most effective in calming your child when he/she is upset? _____

10. What activities does your child like **best**? Favorite toys/games/songs/activities? _____

11. What activities does your child seem to like **least**? _____

12. Are there any special dietary concerns and/or restrictions (e.g. foods not allowed, etc.)? _____

13. What additional aspects of your child's physical and/or emotional development would you like our staff to know about? _____

Additional comments: _____

Parent/Guardian Signature

Date



CAMBRIDGE YOUTH PROGRAMS



HOMEWORK POLICY

(for school year programs)

The mission of the Cambridge Youth Programs is to offer diverse, high quality programs that promote leadership and youth development through enrichment activities, unique experiences, and opportunities to develop relationships with adults and peers. Our programs enable Cambridge youth to thrive and feel a sense of belonging, resulting in young adults who are ready for future employment, higher education, citizenship and adult life.

An essential component of our programs is homework assistance. Each of our afterschool programs offer daily homework assistance. Youth work on their homework in a separate space from other activities, while CYP staff is on hand to offer assistance. While we try our best to ensure youth complete their homework as assigned, the success of our homework room depends on solid communication between CYP staff, youth, parents and teachers. Please review the following policy so that we can work together to help our children achieve academic success:

<p><u>CYP commits to:</u></p> <ul style="list-style-type: none"> * Communicate with families and teachers about youth’s homework assignments and progress * Provide alternate academic materials for youth who do not have homework or finish his/her homework before the allotted homework time ends * Offer guidance when youth are “stuck” * Help youth stay focused and on task * Encourage good work habits * Remove disruptive influences <p><u>CYP expectations of youth:</u></p> <ul style="list-style-type: none"> * Come prepared with homework and assignments * Be honest about homework assignments * Be considerate by working quietly * Only ask for help after trying to complete work on his/her own 	<p><u>CYP cannot commit to:</u></p> <ul style="list-style-type: none"> * Providing one-on-one tutoring * Forcing youth to do their work * Grading or correcting homework assignments * Disciplining youth for not completing work to family’s or teacher’s satisfaction * Ensuring youth <i>complete</i> homework daily <p><u>CYP expectations of parents/guardians:</u></p> <ul style="list-style-type: none"> * Communicate with CYP about youth’s homework and progress in school * Support CYP staff and policies * Encourage your child to display considerate, cooperative behavior * Review and discuss homework with your child
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We understand that families are busy and quite often youth need to complete their homework while in afterschool. When possible, programs will provide additional homework time during activities so that students can continue to work on their homework, with the assistance of an adult. See your home Youth Center for additional, more specific homework information. Finally, CYP is constantly working to provide professional development to our staff to ensure they are best able to support our youth in our homework centers. We work with many partners, including the Cambridge Public School District.

I have read and understand CYP’s Homework Policy:

_____	_____	_____
Printed name of guardian	Signature	Date

_____	_____	_____
Printed name of child	Signature	Date

I have comments/questions/suggestions/concerns: _____

Area IV Youth Center 243 Harvard Street (617) 349-6262	Frisoli Youth Center 61 Willow Street (617) 349-6312	Gately Youth Center 70R Rindge Avenue (617) 349-6277	Moore Youth Center 12 Gilmore Street (617) 349-6273	Russell Youth Center 680 Huron Avenue (617) 349-6314
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**City of Cambridge
Department of Human Service Programs
Information Release Form**

(Child's Name)

(Name of School)

Please circle one: NEW STUDENT

RETURNING STUDENT

I am applying for: (Please circle your program choice.)

**Youth Center
Licensed Programs**

**Community
Schools (CS)**

**Afterschool Licensed
Childcare**

**Preschool Licensed
Childcare**

Area IV
Frisoli
Gately
Moore
MSP @ Frisoli
MSP @ Gately
Russell

Cambridgeport CS
Fitzgerald CS
Fletcher Maynard CS
Haggerty CS
Harrington CS
Kennedy CS
King CS
Linnaean CS
Morse CS
Tobin CS

Fletcher Maynard K-3
King K-2
King 2-4
Morse K-2
Morse 3-5
Peabody K-2
Peabody 2-5

East Cambridge Preschool
Haggerty Preschool
King Open Preschool
M. L. King Preschool
Morse Preschool
Peabody Preschool

(MSP=Middle
School Partnership)

**King Open
Extended Day
(KOED)**

I hereby authorize the Department of Human Services (DHSP) to observe my child in his/her school day classroom or program and to discuss my child's educational, physical, medical, psychological and/or other needs with his/her teachers, specialists, therapists, medical providers and other caregivers for the purpose of evaluating his/her participation in DHSP's out of school time (OST) and preschool programs.

Parent/Guardian Name (Please Print): _____

Parent/Guardian Signature: _____ **Date:** _____

**PERMISSION TO OBTAIN STUDENT RECORDS
(IEP, 504 Plan, behavior plans)**

I hereby authorize my child's school/program to release my child's records including his/her Individualized Education Program (IEP), Behavioral Intervention Plan and/or Section 504 Plan. DHSP will not disclose the content of any such records to any other party without my written consent, except as DHSP may be required by law to do so. All records will be used for the purpose of evaluating my child's participation in DHSP's out of school time (OST) programs.

Parent/Guardian Signature: _____ **Date:** _____

Revised 4/09

Consent to Give Medication in a Department of Human Services Program

In order for medication (prescription and non-prescription) to be given to your child during a Department of Human Services Program (DHSP), this form needs to be completed by both you and your child's doctor or clinic. (Please note: nurses are not on staff at our programs.) Return the completed form to your child's program staff.

Name of Child _____ Date of Birth _____ Program _____

MEDICAL PROVIDER INFORMATION

Diagnosis* _____

Medication _____

Route of Administration _____ Dosage _____

Frequency _____ Time(s) of Administration _____

Date of Order _____ Discontinuation Date _____

Specific directions or information for medication _____

Any other medical condition(s)*/Allergies _____

Dates for next scheduled medical visit _____

Consent for self-administration (provided the primary care provider/parent determine it is safe and appropriate) Yes No

X _____
 Signature of Licensed Prescriber Please Print Name Here Business Telephone Number

Optional Information: (Special side effects, contraindications, or possible adverse reactions; other medications being taken, specific directions for storage)

PARENT/GUARDIAN INFORMATION AND CONSENT

Parent/Guardian Name _____ Parent/Guardian Name _____

Tel # (H) _____ Tel # (H) _____

(W) _____ (W) _____

Other person(s) to be notified in case of medication emergency:

Name: _____ Telephone number: _____

Name: _____ Telephone number: _____

I give permission to have the program staff administer this medication	___ Yes ___ No (Please Initial)
I give permission to the program staff to share information relevant to the prescribed medication administration as s/he determines appropriate for my child's health and safety.	___ Yes ___ No (Please Initial)
I give permission to the program staff to photograph my child, to keep on file for identification purposed only and/or to provide the program with my child's picture if needed.	___ Yes ___ No (Please Initial)
I understand I may retrieve the medication from the program at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order or by the last day of the program.	___ Yes ___ No (Please Initial)
I give permission for the topical application of sunscreen/insect repellent and/or vaseline by staff.	___ Yes ___ No (Please Initial)
I understand the 1 st dose of any medication must be given by the Parent/Guardian unless it is an epi-pen.	___ Yes ___ No (Please Initial)

Parent/Guardian Signature

Date