



SCAN / EL FARO BEACON

2351 First Avenue New York, N.Y. 10035 Office (212) 426-2000 Fax (212) 828-2820

Participant Information

1. Last Name

2. First Name 3. Middle

4. Social Security Number - -

5. Gender Male Female

6. Birth Date / /
Month Day Year

7. Street Address (number and street)

8. Apt # 9. Zip Code

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

11. Home Phone Number (Area code) - -

12. Cell / Pager (Area code) - -

13. Email Address:

14. Ethnicity 1. American Indian 2. Asian (Non-Hispanic) 3. Black (Non-Hispanic) 4. Hispanic/Latino
5. Pacific Islander 6. White (Non-Hispanic) 7. Other

15. Emergency Contact Name Last Name First Name

16. Home Phone Number (Area code) - - 17. Relationship to applicant

18. Emergency Contact 2 Name Last Name First Name

19. Home Phone Number (Area code) - - 20. Relationship to applicant

21. School Attending: _____ School Type: Public School Private School Charter School 22. Grade:

23. Public School Student ID# (OSTS):

24. Primary Language Spoken

25. English Proficient Yes No

26. Are you or any member of your household (0-64 years of age) covered by Medicaid, Child Health Plus, Family Health Plus or private medical insurance? Yes No

27. If NO, do you want to be contacted with information about public health insurance programs? Yes No

28. Are you or any member of your household receiving Public Assistance? Yes No If Yes, HRA Code #:

Parent / Guardian Information

56. Last Name

57. First Name

58. Middle

59. Street Address (number and street)

60. Apt #

61. Zip Code

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

63. Birth Date:

Month Day Year

64. Home Phone Number - 65. Work Phone -

(Area code) (Area code)

66. Cell / Pager Number -

67. Email Address:

68. Ethnicity 1. American Indian 2. Asian (Non-Hispanic) 3. Black (Non-Hispanic) 4. Hispanic/Latino
5. Pacific Islander 6. White (Non-Hispanic) 7. Other

69. Relationship to applicant

70. Primary Language Spoken

71. English Proficient Yes No

Additional Parent / Guardian Information

72. Last Name

73. First Name

74. Middle

75. Street Address (number and street)

76. Apt #

77. Zip Code

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

79. Birth Date:

Month Day Year

80. Home Phone Number - 81. Work Phone -

(Area code) (Area code)

82. Cell / Pager Number -

83. Email Address:

Please continue on the following page



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Swimming Permission Slip

Parental/Guardian Permission for Swimming while participating in the El Faro Beacon Community Center Afterschool Program located @ J.H.S. 45 2351 First Avenue.

I the Parent/Guardian _____ (please print name), declare by my signature below that my child/ward, _____ (please print name), has my permission to participate in swim lessons on the day my child's group is scheduled from the hours of 4:00 p.m. – 6:00 p.m.; while participating in the El Faro Beacon Community Center Afterschool Program.

Please be advised that swimming will be provided to participants between the ages of 6yr. olds to 13yr. olds. The participants will be divided between Beginners – Experienced.

I understand that the swimming pool is on site and that a certified lifeguard will be present while my child is swimming at all times during His/Her swimming session. I also understand that there will be one lifeguard for every twenty five children.

Parent/Guardian Signature

Date

HEALTH RECORD FOR CHILDREN IN DAY CAMPS & AFTERSCHOOL & YOUTH CENTERS
 (This side to be filled in by parent before presentation to physician)

NAME OF PROGRAM _____

| | | | |
|-------------------------|------------------|---------------------|-----------------------------------------------------------|
| CHILD'S LAST NAME _____ | FIRST NAME _____ | BIRTHDATE / / _____ | SEX M <input type="checkbox"/> F <input type="checkbox"/> |
|-------------------------|------------------|---------------------|-----------------------------------------------------------|

Home Address: _____ Phone: _____

Parent or Guardian: _____ Phone: _____

Place of Employment: Father (Guardian) _____ Phone: _____

Mother (Guardian) _____ Phone: _____

In case of emergency, notify: _____ Phone: _____

If Parent, Guardian are not available in an emergency, notify:

1. _____ Phone: _____

or 2. _____ Phone: _____

Important: Has this camper been exposed to any communicable disease during the three weeks prior to camp attendance:
 Yes No (If yes, state type of exposure: _____)

HEALTH HISTORY: (Check box if child has had afflictions, give appropriate dates)

- | | |
|------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Rheumatic Fever _____ | <u>Allergies</u> |
| <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Hay Fever _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Poison Ivy, etc. _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Insect Stings _____ |
| <input type="checkbox"/> Chicken Pox _____ | <input type="checkbox"/> Penicillin _____ |
| | <input type="checkbox"/> Other Drugs _____ |
| | <input type="checkbox"/> Food _____ |

Other Past Illnesses _____

Operations or Serious Injuries (Dates) _____

Hospitalization (Dates) _____

Chronic or Recurring Illness _____

Any specific activities to be encouraged? _____

Conditions that require activity to be restricted? _____

Permission for all program activities unless otherwise noted by Dr. _____

Appliance worn (glasses, contacts, etc.) _____

Medication taken _____

Suggestion from Parent/Guardian _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I do hereby give authority to the Day Camp and Year Round Afterschool and Youth Center Program staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Relationship _____ Signature _____ Date _____ Tel.# _____

PHYSICAL EXAMINATION

(To be filled out by Physician - please note information on reverse side)

The purpose of this health record is to provide the staff with pertinent information which will help to serve the needs of this child in Day Camps and Afterschool and Youth Center programs.

IMMUNIZATION HISTORY - This is a record of dates of basic immunization and most recent booster doses.

Table with 6 columns for dates and rows for DTaP, Polio, MMR, Hemophilus Influenzae type b (Hib), Hepatitis B, Varicella, Pneumococcal Conjugate (PCV), and Other.

MEDICAL EXAMINATION - To be filled out by licensed physician.

Examination is acceptable when performed no more than 12 months prior to arrival at camp.

- Code: S = Satisfactory
X = Not Satisfactory (Explain)
0 = Not Examined

General Appearance
Genitalia
Height Weight Blood Pressure Posture & Spine Throat - Tonsils
Nose Teeth Abdomen Hernia Feet Lungs Skin
Hgb. Test (Date) Urinalysis (Date)
Eyes Vision w/Glasses Extremities Heart
Ears Hearing
Neurological Findings
Describe Abnormal Findings and/or Handicapping Conditions
Allergy: (Please specify)

Recommendations and restrictions while in camp:

Special Diet
Special Medicine (dose, route of administration, when should it be administered)
Is parent/guardian sending special medicine?
Activity Restrictions
Swimming Diving

General Appraisal:

I have examined the person herein described, reviewed his/her health history and it is my opinion that he/she is physically able to engage in Day Camp/Year Round Afterschool and Youth Center activities, except as noted above.

M.D.
EXAMINING PHYSICIAN (SIGNATURE)
PHYSICIAN'S NAME (PLEASE PRINT)

Telephone Address

Date of Examination



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Photo/Video Consent Form (To be completed by the parent or guardian)

I certify that I am the parent or legal guardian of _____ whose date of birth is _____
(Child's Name) (Birthday date)

I understand that _____ staff, as well as photographers, newspaper and television reporters,
(Agency)
media representatives and public relations personnel may be present during program activities and special events both in-school and away from school. In some cases, they may photograph, interview or otherwise record children who participate in these activities and events. The resulting images, videos, and interviews may be used to promote the programs in printed and electronic media published by our agency, such as brochures, books, print and email newsletters, DVDs and videos, websites and blogs. These images, videos and interviews may also be used by New York City's Department of Youth and Community Development (DYCD) in its publications.

I give permission for my child to be photographed, interviewed or otherwise recorded during program activities and special events, and for the resulting images and text to be used by _____ or DYCD in any
(Agency)
medium, whether now or hereafter known or developed.

Signature of Parent/Guardian: _____ Date: _____

If you do not wish for your children to participate in interviews or the recording of images as described above, please review this section of the form.

I DO NOT give permission for photographs, other recordings or interviews of my child to be used by the program or DYCD in any publication. As a result, my child may not be able to participate in events and group activities that may be used for publication purposes.

Signature of Parent/Guardian: _____ Date: _____

Parent Consent to Participate in Evaluations of the Beacon Center Program

Dear Parent,

Your child, _____, is enrolled in the Beacon program at _____, which is supported by Department of Youth and Community Development (DYCD). To monitor the effectiveness of the Beacon program and ensure its future success, DYCD and the evaluation firm Policy Studies Associates (PSA), are conducting ongoing evaluations. The information collected will help DYCD learn about participants' experiences in the program, how the program helps participants, and how the program can be improved.

Specifically we ask permission for DYCD and PSA to:

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

Any information we collect will be used only to assess the Beacon program and will not be made public. Participating in the evaluations will not affect your child in school, in the Beacon 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 evaluations, we will destroy all records that include personal information. Participation in evaluations 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 Beacon 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 evaluations of the Beacon program.

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 evaluations of the Beacon program.

Signature

Date

If you have any questions or concerns, please contact the Beacon Director or Gianna Abruzzo, DYCD Outcomes Monitoring and Evaluation Project Manager, at 212-788-9480 or gabruzzo@dycd.nyc.gov.



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RULES & REGULATIONS

1. Adult members present their Beacon membership card to the security desk to obtain access to the facility. No member will be admitted without presenting His/Her membership card (No Exceptions).
2. No member will give his/her membership card to any other person to gain access to the Beacon Center.
3. Members will follow the directions of all El Faro Beacon Community Center staff.
4. No weapons or drugs allowed in the center.
5. There is no gambling allowed in the center.
6. Members will not be allowed in the facility while under the influence of drugs or alcohol.
7. Members will respect other people's rights and their property.
8. Members will not damage or destroy the property or equipment of the EL FARO BEACON COMMUNITY CENTER.
9. No hats or caps to be worn in the Beacon Center.
10. Members will check in all coats and outer garments at the Drop on Lounge after signing into the facility.
11. No swearing or cursing of any kind is allowed.
12. No clothing with profanity can be worn at the Beacon Center.
13. There will be no physical confrontation in the center.
14. There is no fighting allowed in the center, or fighting outside the center that started from a confrontation in the Beacon Center.
15. Food and drinks are only allowed in designated areas.
16. A member will be required to perform 10 hours of community service at the Beacon Center to obtain a replacement membership card.
17. Parents are obligated to pick up their children at designated dismissal times except those that have signed the permission portion of the application to allow their children to go home unaccompanied.
18. Parents are not allowed to confront any Beacon member or staff member that was involved in an incident with your child. In the interest of peaceful resolution we ask that mediation with the Director Michael Melendez, the Coordinator Renee Charlton, or Senior Counselor Denise Manning.

*VIOLATION OF THE RULES MAY RESULT IN SUSPENSION OR REMOVAL FROM
THE "EL FARO BEACON COMMUNITY CENTER".*