Data Clerk Initials:

_____

Funded in full or in part with a grant by the Pennsylvania Department of Education

OST PROGRAM
INTAKE/DISCHARGE FORM FALL 2017/2018

SITE: _____ Intake Date: _____

Child's Name: _____ *(Please Print Clearly)*

Child's Social Security #: _____ Date of Birth: _____

Child's Pupil Identification Number: _____

Child's School: _____ **Grade child will be entering Fall 2017:** _____

Child's Gender: ___Male ___Female T-Shirt Size: _____

Caregiver's Information

Name: _____ Relationship to child: _____

Home Address: _____ Zip Code: _____

Home: _____ Cell: _____ Work: _____

Email Address: _____

Date of most recent Health Assessment on file: _____

This information is collected for statistical purposes only.

_____

Child's Race: _____ African American _____ Asian or Pacific Islander ___ White ___ Multi Ethnic
_____ African ___ Other (Specify) _____

_____

FOR OFFICE USE ONLY:
Discharge Date: _____
Reason Discharged: ___ Moved ___ Medical ___ Family Situation ___
Outside Activity Participation _____
___ Poor Attendance ____ Behavioral ___ Other (Please Explain): _____

EMERGENCY CONTACT/PARENTAL CONSENT FORM – **PLEASE PRINT CLEARLY – FALL 2017/2018**

55 PA CHAPTERS 3270 124 (a) (b) 181 & 182 3280 124 (a) (b) 3260 181 & 182 3290 124 (a) (b) 3290 181 & 182

CHILD'S NAME			BIRTH DATE
ADDRESS	CITY	STATE	ZIP
MOTHER'S NAME/LEGAL GUARDIAN			HOME TELEPHONE NUMBER
ADDRESS	CITY	STATE	ZIP
BUSINESS NAME			BUSINESS TELEPHONE NUMBER
ADDRESS	CITY	STATE	ZIP
FATHER'S NAME/LEGAL GUARDIAN			HOME TELEPHONE NUMBER
ADDRESS	CITY	STATE	ZIP
BUSINESS NAME			BUSINESS TELEPHONE NUMBER
ADDRESS	CITY	STATE	ZIP

EMERGENCY CONTACT PERSON (S)

NAME: _____ ADDRESS: _____

TELEPHONE NUMBER WHEN CHILD IS IN CARE: _____

EMERGENCY CONTACT PERSON (S)

NAME: _____ ADDRESS: _____

**TELEPHONE NUMBER WHEN CHILD IS IN CARE: _____

PERSON (S) TO WHOM CHILD MAY BE RELEASED

NAME: _____ ADDRESS: _____

TELEPHONE NUMBER WHEN CHILD IS IN CARE: _____

NAME: _____ ADDRESS: _____

TELEPHONE NUMBER WHEN CHILD IS IN CARE: _____

NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER

NAME			TELEPHONE NUMBER
ADDRESS	CITY	STATE	ZIP

SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTION)
MEDICAL OR DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICAL SPECIAL CONDITIONS
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD	
HEALTH INSURANCE COVERAGE FOR CHILD OR MEDICAL ASSISTANCE BENEFITS	POLICY NUMBER (REQUIRED

PARENT'S SIGNATURE REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT

OBTAINING EMERGENCY MEDICAL CARE - Parental signature required	ADMIN. OF MINOR FIRST-AID PROCEDURE - Parental signature required
WALKS AND TRIPS - Parental signature required	SWIMMING - Parental signature required
TRANSPORTATION BY THE FACULTY - Parental signature required	WADING - Parental signature required

Periodic Review

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

235% MEANS TEST WORKSHEET

I. IDENTIFYING INFORMATION FOR "SERVICES FOR NON-PLACED CHILDREN"

1. CHILD'S NAME (LAST, FIRST, M.I.) (PLEASE PRINT CLEARLY)		2. SEX: ☐ MALE ☐ FEMALE
3. CHILD'S DATE OF BIRTH	4. CHILD'S SSN	5. COUNTY IDENTIFIER 51
6. PERSON WITH WHOM THE CHILD IS LIVING	7. RELATIONSHIP TO CHILD	8. SSN OF PERSON WITH WHOM CHILD IS LIVING
9. AGENCY NAME EducationWorks	10. PROGRAM NAME **	11.

II. MEANS TEST FOR "SERVICES FOR NON-PLACED CHILDREN"

1. Is the child/family receiving ☐ TANF (Cash Assistance) ☐ SSI ☐ FOOD STAMPS ☐ MEDICAID NONE ☐ Case #: _____

If services are being received, proceed to question 5 and answer "YES." If response is "NONE," proceed to question 2.

2. Is the child a U.S. Citizen or qualified alien? ☐ **YES** ☐ **NO** If yes, indicate source of citizenship information**:** ☐ Birth Certificate, ☐ INS, ☐ Eligibility for TANF, SSI, Food Stamps, or Medicaid or ☐ Self-Declaration

3. Is the child under 18 years of age? ☐ **YES** ☐ **NO**

4. In order to be eligible for "services for non-placed children," a child's/family's gross income may not exceed 235 percent of the Federal Poverty Level (FPL) for the family unit size. Using Table 1 below, provide a **"YES"** or **"NO"** in Column 4 in the corresponding row for the family size as to whether the child/family's income **is less than** the annual or monthly amount for the family size. (Family unit includes biological or adoptive parents, specified relatives, or non-relative court designated legal custodians and full, half, and/or adopted siblings living in the home under the age of 18 plus the TANF child). This is a self-declared means test. No verification except the response of the family is required.

Table 1: 235 Percent of Federal Poverty Level

(1) Family Unit Size	(2) 235% of FPL (Gross Annual)	(3) 235% of FPL (Gross Monthly)	(4) (YES or /NO)
1	Less than $24,440	Less than $2,037	
2	Less than $32,900	Less than $2,742	
3	Less than $41,360	Less than $3,447	
4	Less than $49,820	Less than $4,152	

Note: For family units of more than 4 members, add $8,460 annually (Column 2) and $705 monthly (Column 3) for each additional member and place the correct figures in the blank row at the bottom of Table 1

5. Is the child living in the home of a parent, other adult specified relative or a court designated legal custodian?
☐ **YES** ☐ **NO**

6. Is the child/family receiving one of the benefits in question 1 or answers to questions 2, 3, 4 and 5 are ALL "YES"?
☐ **YES** ☐ **NO**

If **"YES,"** the child is eligible for TANF funding for services for non-placed children.

**Means Test Administered for: Month: ****_____ **Year: ****_____

7. Name of staff person administering this means test (Please Print) ** _____

8. Date this form was completed: ** _____ _____

400% MEANS TEST WORKSHEET

I. IDENTIFYING INFORMATION FOR "SERVICES FOR NON-PLACED CHILDREN"

12. CHILD'S NAME (LAST, FIRST, M.I.) (PLEASE PRINT CLEARLY)		13. SEX: ☐ MALE ☐ FEMALE
14. CHILD'S DATE OF BIRTH	15. CHILD'S SSN	16. COUNTY IDENTIFIER 51
17. PERSON WITH WHOM THE CHILD IS LIVING	18. RELATIONSHIP TO CHILD	19. SSN OF PERSON WITH WHOM CHILD IS LIVING
20. AGENCY NAME EducationWorks	21. PROGRAM NAME **	

II. MEANS TEST FOR "SERVICES FOR NON-PLACED CHILDREN"

1. Is the child/family receiving ☐ TANF (Cash Assistance) ☐ SSI ☐ FOOD STAMPS ☐ MEDICAID NONE ☐ Case #: _____

If services are being received, proceed to question 5 and answer "YES." If response is "NONE," proceed to question 2.

2. Is the child a U.S. Citizen or qualified alien? ☐ **YES** ☐ **NO** If yes, indicate source of citizenship information**:** ☐ Birth Certificate, ☐ INS, ☐ Eligibility for TANF, SSI, Food Stamps, or Medicaid or ☐ Self-Declaration

3. Is the child under 18 years of age? ☐ **YES** ☐ **NO**

4. In order to be eligible for "services for non-placed children," a child's/family's gross income may not exceed 400 percent of the Federal Poverty Level (FPL) for the family unit size. Using Table 1 below, provide a **"YES"** or **"NO"** in Column 4 in the corresponding row for the family size as to whether the child/family's income **is less than** the annual or monthly amount for the family size. (Family unit includes biological or adoptive parents, specified relatives, or non-relative court designated legal custodians and full, half, and/or adopted siblings living in the home under the age of 18 plus the TANF child). This is a self-declared means test. No verification except the response of the family is required.

Table 1: 400 Percent of Federal Poverty Level

(1) Family Unit Size	(2) 400% of FPL (Gross Annual)	(3) 400% of FPL (Gross Monthly)	(4) (YES or /NO)
1	Less than $41,600	Less than $3,460	
2	Less than $56,000	Less than $4,667	
3	Less than $70,400	Less than $5,867	
4	Less than $84,800	Less than $7,067	

Note: For family units of more than 4 members, add $14,460 annually (Column 2) and $1,200 monthly (Column 3) for each additional member and place the correct figures in the blank row at the bottom of Table 1

5. Is the child living in the home of a parent, other adult specified relative or a court designated legal custodian?

☐ **YES** ☐ **NO**

6. Is the child/family receiving one of the benefits in question 1 or answers to questions 2, 3, 4 and 5 are ALL "YES"?

☐ **YES** ☐ **NO**

If **"YES,"** the child is eligible for TANF funding for services for non-placed children.

Means Test Administered for: Month: **_____ Year: **_____

6. Name of staff person administering this means test (Please Print) **_____

7. Date this form was completed: ** _____ _____

PARENT OR GUARDIAN CONSENT FORM
Fall 2017/2018

Funded in full or in part with a grant by the Pennsylvania Department of Education

Name of Child: _____

Name of Parent or Guardian: _____

Site:_____Date:_____

CONSENT FOR USE OF PERSONAL IMAGE

While in the EducationWorks program, I give permission to display in the news media or electronically via the Internet or in other displays, the artwork created by my child. I consent to have my child's artwork, name, grade level, and school displayed, allowing this artwork and information to be viewed by the public.

I also grant to EducationWorks permission to display in the news media or electronically via the internet and in other displays, photographs, and/or video footage of my child taken in connection with his or her participation in the non-school hour programs provided through EducationWorks.

CONSENT FOR CHILD TO WALK HOME

I grant permission to EducationWorks Program to release my child at dismissal to walk home alone. I understand that EducationWorks will not be liable for anything that happens to my child once he/she leaves the program at dismissal time.

If there are any special instructions for walking home (i.e. my student may only walk home with her older brother/sister) please describe below.

_____

_____

_____

Please Note: A child will NOT be released to anyone whose name does not appear on the emergency contact form. This applies to all children, including those who walk home by themselves

CONSENT TO RELEASE REPORT CARD

During the 2017/2018 OST Program EducationWorks intends to work with students in a motivational program to raise their grades. This will require that you submit a copy of each of your child's report cards to the EducationWorks Site Coordinator at your child's summer camp program. With a counselor's assistance, children will formulate a plan to raise a grade by the next report card. We will keep you informed as this project progresses. Please sign below indicating that you will provide EducationWorks with a copy of your child's report card so that your child can participate in this effort. When not being used with your child and his/her counselor, his/her report card will be kept in your child's confidential file**. I have read and understand the above information. I agree to submit a copy of my child's report card in a timely manner.**

CONSENT TO USE HAND SANITIZER

I am aware that in the absence of soap and water, EducationWorks Program staff will administer hand sanitizer to my child.

PARENT'S SIGNATURE REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT	
MEDIA CONSENT – Parental signature required	**CONSENT TO WALK HOME** – Parental signature required
REELEASE OF REPORT CARD - Parental signature required	**USE OF HAND SANITIZER** - - Parental signature required

AGREEMENT FALL 2017/2018

55 PA CODE CHAPTERS 3270.123 &.181(C); 3280.123 &.181(c); 3290.123 &.181(c)

NAME OF CHILD		
FEE AMOUNT $ 0 PHMC Scholarship	PER-DAY-WEEK N/A	DAY PAYMENT TO BE MADE N/A
Services to be provided as part of the day care fee (examples; transportation, care, meals, etc.)		
Breakfast, lunch, snacks, fun projects, arts and crafts, academic enrichment, outdoor activities, trips, and swimming		
CHILD'S ARRIVAL TIME: 3:09 PM	CHILD'S DEPARTURE TIME: 5:45 PM	PERSON-IS) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
LATE FEE: $1.00	PER MIN-HR: PER MINUTE	
Extra services to be provided at an additional fee If applicable: N/A		

I, the parent/guardian;

		received complete written program Information at the time of enrollment. (§ 3270.121,3280.211, 3290.121) 3280.121, 3290.121)
		agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minimum (3270.124, 3280.124, 3290.124)

SIGNATURE-OPERATOR	DATE	SIGNATURE-PARENT OR GUARDIAN	DATE

DATE OF CHILD'S ADMISSION	PERIODIC REVIEW.•
DATE OF WITHDRAWAL	SIGNATURE-PARENT OR GUARDIAN DATE

Public Health Management Corporation
Out-of-School Time Project
Consent to Collect Information
July 1, 2017 to June 30, 2018

EDUCATIONWORKS _____

Agency Name

_____

Program Location and Model

Purpose:
The City of Philadelphia's Department of Human Services (DHS) funds over 200 after-school programs through the Out-of-School Time (OST) program. The City has a contract with Public Health Management Corporation (PHMC). PHMC manages the OST program your child attends. When you enroll your child in OST, PHMC will collect information from you to help manage the program. If you agree, we will also ask you and your children questions about OST to make the program better.

Process:
When you sign-up for an OST program, PHMC will ask you some questions about your child, such as his name, age and address, You will complete this information on the program's registration forms. This information will be entered into a database at PHMC. Staff at PHMC and the City will be able to see this information and use it to improve the OST program. OST staff may also visit the program and talk to your child about being at that program. This is a basic part of OST for every child and every after-school site.

To learn more about your experience with OST, PHMC may ask you and your child to complete short surveys, These surveys will be given at the start and at the end of the school year during regular after-school time, The survey will ask questions about what you and your child think about the program.

Information Privacy and Sharing:
The information that we collect about your child will not be shared with anyone outside of the OST program. All of the information is stored in a database that is protected by a password. Only approved staff at PHMC or the City can see the information.

We will never share any single child's answers. We will only share results from the survey for the OST program as a whole.

Voluntary Surveys:
You can decide if you want your child to participate in the OST surveys. You can decide not to participate. This will not in any way affect your child's chance to enroll in the program.

Questions:
If you have any questions about this form, you may contact: PHMC @215-825-8203 or ost@phmc.org.

PLEASE CHECK ONE OF THE BOXES and SIGN BELOW:

☐ **Agreement to Participate:** I have read and understand this form. I agree to allow my child to answer the surveys.

☐ **Refusal to Participate:** I have read and understand this form. I do NOT give permission for my child to answer the surveys.

_____
Child's Name

_____

Parent/Guardian's Name Parent/Guardian's Signature Date

The City of Philadelphia
Out-of-School Time Project

CONSENT TO RELEASE EDUCATION RECORDS UNDER FERPA

Student: _____ Student ID #: _____

The Out-of-School Time Project ("OST") is a Philadelphia effort to improve the well-being of children and youth through effective academic support, enrichment and youth development activities during non-school hours. OST programming provides safe, constructive activities to children when they are not in school, and has been demonstrated to improve in-school performance.

In order to assess and improve the quality of OST programs, The City of Philadelphia Department of Human Services (the "City") asks for permission to collect personally identifiable information from education records regarding children's school performance. The City will collect standardized test scores, report cards and school attendance, disciplinary and other relevant school records ("education records"). The City will use these education records to measure the impact of OST programming on childrens' school performance and to improve the quality of those programs.

I am the parent or guardian of the student named above ("Student"). As authorized by applicable law, including but not limited to the Family Education Rights and Privacy Act, 20 U.S.C. 1232g, and 34 C.F.R. Part 99 ("FERPA"), I consent and authorize The School District of Philadelphia (the "School District") to release education records concerning the Student, including confidential records of the School District, to the City's Department of Human Services, the Public Health Management Corporation, and my Student's OST program ("Recipients").

The School District releases these education records in connection with the Student's participation in an OST program. The School District may disclose these education records only to the Recipients, and the Recipients may share this information only with other named Recipients, and with the Recipients' officers, staff, administrators and independent contractors under the Recipients' control. The Recipients may use these education records to research, study or evaluate OST programs.

If I ask, the School District will provide me with a copy of the records disclosed.

FERPA and other applicable laws protect the confidentiality of and your right to privacy concerning the Student's education records. The Recipients shall keep all information concerning the Student confidential and private to the fullest extent provided by applicable laws, including FERPA. Neither The School District nor the Recipients require me to waive any rights under these laws, and I give my consent voluntarily.

_____ _____

Parent/Guardian Signature (or Student's signature, if Student is 18 years old or an emancipated minor) | Date

_____ _____

Name of school in which Student is currently enrolled | Student's Grade

EducationWorks

Name of Student's OST Provider Agency | Student's Date of Birth

_____

Name of Student's OST Provider Location

INDIVIDUALIZED EDUCATION PLANS (IEP)

Dear Parent,

If your child has an Individualized Education Plan (IEP) it would be beneficial to share a copy of this plan with us so we can work together and with your child's teacher to ensure that the guidelines in the plan are put into practice.

The information in the plan will be shared with no one except your child's Group Leader and the Site Coordinator of the After School Program.

You do not have to provide this information if you do not wish to do so.

However, please complete the form below.

****

Parent Sign-off Sheet

Child's Name:_____

☐ I am providing a copy of my child's IEP or IFSP.

☐ I am not providing a copy of my child's IEP or IFSP and/or this is not applicable to my child.

Signature:_____ **Date:**_____

Printed Name:_____

Child Health Assessment

Parents & Child Care Providers fill-in this part.

Child's Name: (Last)	(First)	Parent/Guardian:
Date of Birth:	Home Phone:	Address:
Child Care Facility Name:		
Facility Phone:	County:	Work Phone:

To Parents: Submission of this form to the child care provider implies consent for the child care provider to discuss the child's health with the child's clinician.

PA child care providers must document that enrolled children have received age appropriate health services and immunizations that meet the current schedule of the American Academy of Pediatrics 141 Northwest Point Blvd., Elk Grove Village, IL 60007. The schedule is available at <www.aap.org> or Faxback 847/758-0391 (document #9535 and #9807). Print copies provided by DPW have the schedule on the back of the form.

Health history and medical information pertinent to routine child care and emergencies (describe, if any): ☐ NONE	Date of most recent well-child exam:
Allergies to food or medicine (describe, if any): ☐ NONE	Do not omit any information. This form may be updated by health professional. (Initial and date new data.) Child care facility needs 2 copies.

LENGTH/HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	BLOOD PRESSURE
_____IN/CM % ILE _____	_____LB/KG % ILE _____	(Birth to Age 2) _____IN/CM % ILE _____	(Beginning at age 3) _____ / _____

PHYSICAL EXAMINATION	☑ = NORMAL	If ABNORMAL - COMMENTS
Head/Ears/Eyes/Nose/Throat		
Teeth		
Cardiorespiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurologic & Developmental		

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
DTa/DTP/Td						
POLIO						
HIB						
HEP B						
MMR						
VARICELLA						
PNEUMOCOCCAL						
OTHER						

SCREENING TESTS	DATE TEST DONE	NOTE HERE IF RESULTS ARE PENDING OR ABNORMAL
LEAD		
ANEMIA (HGB/HCT)		
URINALYSIS (UA) (at age 5)		
HEARING (subjective until age 4)		
VISION (subjective until age 3)		
PROFESSIONAL DENTAL EXAM		

Health Problems or Special Needs, Recommended Treatment/Medications/Special Care (attach additional sheets if necessary)

☐ NONE

NEXT APPOINTMENT - MONTH/YEAR:

Parents may write immunization dates, health professionals should verify and complete all data.

Medical care Provider:		Signature of Physician or CPNP:	
Address:			
	Phone:	License Number:	Date Form Signed: