Department of Youth & Community Development

WELCOME!

DYCD OVERVIEW

The Department of Youth and Community Development (DYCD) is a New York City agency that funds programs for youth and families. These programs are operated by community-based organizations (CBOs). DYCD thanks you for enrolling yourself or your child in this program.

ENROLLMENT PACKET OVERVIEW

Please answer all the questions below to help us provide quality services. Those marked with an asterisk (*) are mandatory. If there is a question that you do not understand, please seek help. You can speak with a worker at the CBO that operates the program or call 311 and request the DYCD Youth Hotline. DYCD also has a website www.nyc.gov/dycd and can be followed on Facebook and Twitter for additional information on DYCD services.

This enrollment packet will allow you or your child to be enrolled in this program. The information captured through this form will help the program plan to provide a safe and healthy environment, and provide appropriate services. Enrollment packet sections:

- Welcome and Packet Overview (this page)
- Participant Background (page 2)
- Participant Health and Safety (page 3)
- Signatures (page 4)
- Parent Consent Forms
- Other _____

Please save this page for your records and future reference.

BEACON programs are school-based community centers serving children age 6 and older and adults. There are currently 80 Beacons located throughout the five boroughs of New York City, operating in the afternoons and evenings, on weekends, during school holidays and vacation periods, including summer.
▪ Elementary School (K-5th Grade) ▪ High School (9th-12th Grade)
▪ Middle School (6th-8th Grade) ▪ Adults (18 Years Old and Above)
COMPASS programs comprise more than 800 programs serving young people enrolled in grades K-12. Programs are offered at no cost to young people and are strategically located in public and private schools, community centers, religious institutions, public housing, and recreational facilities throughout the City.
▪ Elementary School (K-5th Grade) ▪ Transition to High School (THS) (9th Grade)
▪ SONYC Middle School (6th-8th Grade) ▪ Option II
CORNERSTONE programs provide engaging, high-quality, year-round programs for adults and young people. Programs are located at 70 New York City Housing Authority (NYCHA) Community Centers throughout the five boroughs.
▪ 5-12 Years Old ▪ 16-21 Years Old
▪ 13-15 Years Old ▪ Adult

DYCD PROGRAM

1 PARTICIPANT BACKGROUND

Department of Youth & Community Development

Primary Parent / Guardian of Participant:	Who is enrolling in this program? ☐ My child ☐ Me *To register yourself, you must be 18+ years old.*
Primary Number:	**Email Address:*** ☐ No Email

participant contact information

Date		**Program Period**	
Last Name*		**First Name***	
Date of Birth*		**Cell Phone**	
Home Address*		**Apartment Number**	
City*		**State***	
Zip Code*		**Borough**	
Home Phone		**Proof of ID**	☐ Birth Certificate ☐ Passport ☐ Driver's License ☐ Non-Driver State ID ☐ Official Letter ☐ Municipal ID
NYCHA Resident*	☐ Yes ☐ No		
Gender*	☐ Female ☐ Male ☐ Other:		

demographics

Country of Origin		**English Proficient***	☐ Yes ☐ No
Ethnicity*	☐ American Indian or Alaskan Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ☐ No Response		
Primary Language Spoken at Home*		**Additional Language(s)**	

student or employment status

Current Grade Level		**Student ID/OSIS #**	
Teacher/ Advisor		**School Type**	☐Public ☐Charter ☐Private ☐Other
School Name		**School Address**	
Student Status	Is the participant a student: ☐ Yes ☐ No	**If yes:**	☐ Full-time ☐ Part-time
If you are NOT a student, please provide the last school grade level completed:		☐ Grade K-11; please list your last grade: _____ ☐ HS Graduate ☐ HS Equivalency ☐ Some College ☐ College Degree	
If you are NOT a student, are you:		☐ Unemployed for _____ weeks ☐ Employed Full-time ☐ Employed Part-time	

other

Please list anyone else in your household who is participating in this program. Provide first and last names.

DYCD PROGRAM

❷ PARTICIPANT SAFETY

Department of Youth & Community Development

If there is an emergency, please contact the following individuals:

❶

NAME*		**RELATIONSHIP TO PARTICIPANT:**	
Pick Up*	☐ This person may pick up my child.	**Contact**	Write down all numbers and circle the best number to call in case of an emergency:
Address			☐ Home _____
City, State			☐ Cell _____
Zip Code			☐ Work _____
			☐ Email* _____ ☐ No Email

❷

NAME*		**RELATIONSHIP TO PARTICIPANT:**	
Pick Up*	☐ This person may pick up my child.	**Contact**	Write down all numbers and circle the best number to call in case of an emergency:
Address			☐ Home _____
City, State			☐ Cell _____
Zip Code			☐ Work _____
			☐ Email* _____ ☐ No Email

❸ PARTICIPANT HEALTH INFORMATION

Please check any of the following that pertain to the participant. Many needs or health challenges can be accommodated and may not limit enrollment in the program.

☐ Allergies to food
☐ Allergies to medications
☐ Allergies other (please Specify)
☐ Asthma
☐ Behavioral/Emotional Issues
☐ Convulsions/Seizures
☐ Congestive Illness (e.g., heart murmur/disease, blood pressure)
☐ Corrective Devices (e.g., crutches, hearing aid, eye glasses)
☐ Diabetes
☐ Individualized Education Plan
☐ Obesity
☐ Other (please specify)
☐ Physical Disabilities
☐ Pregnant

Check off all that apply.

☐ Does your child have special health care needs that require treatment and/or medication?
☐ Does your child take medication for any condition or illness?
☐ Updated Medical Information on File:
☐ Are there any activities your child cannot participate in? (If so, please specify below)

Activities your child cannot participate in:

☐ 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?
☐ If NO, do you want to be contacted with information about public health insurance program?

This section is only for parents enrolling their children.

PICK UP/DISMISSAL INFORMATION.

My child has permission to walk home alone at dismissal. ☐ Yes ☐ No

My child MAY NOT be picked up by: _____

DYCD PROGRAM

❹ ADDITIONAL BACKGROUND

Department of Youth & Community Development

other family and household information

The participant lives in housing that is: *(Check all that apply)* ☐ Rental ☐ Family Owned ☐ NYCHA housing OR The participant is: ☐ Homeless ☐ Other:			
Is or has the participant ever been in foster care:			☐ Yes ☐ No
Has the participant been enrolled in programs operated by the Administration for Children's Services (ACS)?			☐ Yes ☐ No
Number of individuals in your household:			
Is the participant or any member of your household receiving public assistance?			☐ Yes ☐ No
Is the participant or any member of your household receiving food stamps?			☐ Yes ☐ No
Gross Yearly Household Income:			$ _____
The participant lives in a household that is headed by:	☐ Self, Single, no children	☐ Single Female Parent ☐ Single Male Parent	☐ Two Parents ☐ Two Adults, no children
Sources of household income:			
☐ Employment	☐ TANF	☐ Social Security	☐ Unemployment Insurance
☐ Pension	☐ SSI	☐ General Assistance	☐ Other _____
Would you like information on voter registration?		☐ Yes ☐ No ☐ I am already a registered voter	

SIGNATURES

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 or to access additional funding.

I have completed this application for my child.

Parent/Guardian: _____ _____ _____
(Print) (Sign) (Date)

I have completed this application for myself.

Applicant: (18 and older) _____ _____ _____
(Print) (Sign) (Date)

Organization: _____

Intake Specialist/Staff: _____ Date: _____

DYCD PROGRAM

PARTICIPANT INTERST SURVEY

Interests/Activities	☑ Likes/Strengths	👎 Dislikes/Challenges
Reading		
Math		
Media (digital art, photography, videography)		
Writing(poetry, short fiction, journaling)		
Art (painting, drawing, sculpturing)		
Performance (music, dance, drama)		
Science Technology Engineering Math/STEM		
Sports (team, individual)		
Video Games		
Board Games		
Cooking & Nutrition		
Gardening		

How we can be helpful to you/your child? Are there are other services or activities that would be interesting and or helpful to you/your child? _____

Does your child have an Individualized Education Plan and/or Special Needs? ☐ Yes ☐ No

Please use the space below or on the back of the page to provide details or list goals you would like to share with us.

OTHER SERVICES

*Please check any other DYCD services you or your family might be interested in learning more about?

- ↑ Education/Literacy/High School Equivalency
- ↑ Adolescent Literacy
- ↑ Fatherhood Services
- ↑ Housing Assistance
- ↑ Immigrant Services
- ↑ LGBTQ Support Services
- ↑ Runaway and Homeless Youth
- ↑ Senior Services
- ↑ Summer Youth Employment
- ↑ Young Adult Internships
- ↑ Workshops/Fairs (College Prep, Financial Planning, Parenting, etc.)

Parent/Guardian Consent

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.

Consent to Collect and Share Student Information

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 need.

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, 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: _____
Additional Parent/Guardian Signature*: (optional)* _____

Consent for Photo/Videotaping and Use of Youth Work

Please be aware that sometimes staff, photographers, newspapers, television reporters, media representatives and public relations personnel may be present during program activities and special events, both at off-site events and events taking place in the usual program location. In some cases, they may photograph, videotape, interview or otherwise record children who participate in these events. The resulting images, videos and interviews may be used solely for non-profit, non-commercial purposes in printed and electronic media such as brochures, books, print and email newsletters, DVDs and videos, websites, social media and blogs (collectively, "Media"). These images, videos and interviews may be used by DYCD and third-party organizations that collaborate with DYCD, without compensation and without further approval, solely for non-profit, non-commercial purposes.

If, in the course of participating in program activities or special events, any original work is created by a participant, DYCD may use the created work in any and all Media to promote the program or for other informational, non-profit and non-commercial purposes, without compensation and without further approval.

- I understand my child may be photographed, interviewed or otherwise recorded during program activities and special events and give permission for my child to be photographed, interviewed or otherwise recorded solely for non-profit, non-commercial purposes of the program.
  ___Yes, I give my permission ___ No, you do not have permission

- I understand that my child's work may be used in materials that promote programs, solely for non-profit, non-commercial purposes of the program.
  ___Yes, I give my permission ___ No, you do not have permission

Consent for Emergency Medical Treatment

I give authority to the Program Agency's staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible. I understand that every effort will be made to contact me before and after medical care is provided.

___Yes, I give permission ____No, I do not give permission

Consent Statement

I the undersigned, certify that I have reviewed all the above consent statements and indicated my wishes. I understand that consent is voluntary and I can withdraw it in writing at any time.

_____ _____
Student/Applicant Name Student Signature (***if 18 or older***)

_____ _____
Parent/Guardian Name Parent/Guardian Signature Date

_____ _____
Additional Parent/Guardian Name (*optional)* Additional Parent/Guardian Signature Date

Department of Youth & Community Development

Agency: _____

School: _____

Parent Consent for Participation in Data Collection

Dear Parent:

Your child is enrolled in a program that is supported by the Department of Youth and Community Development (DYCD). In order to monitor the effectiveness of this program and ensure its future success, DYCD, and its evaluation partner American Institutes for Research (AIR), are collecting information about participants and their experiences in the program. AIR is doing a study of the middle school programs that are part of COMPASS – known as School's Out New York City (SONYC) programs; the study is called *School's Out NYC: Out-of-School Time Middle School Expansion Evaluation Services*. This project has been approved by the Department of Education (DOE). AIR will visit some of the programs to learn more about SONYC and how it can be improved and will collect information from young people in the program.

We ask permission from parents to conduct the following study activities:

- Survey children about the DYCD program.
- Survey children about themselves (what they have learned).
- We may access your child's school information from NYC DOE, including demographic data, school day attendance, disciplinary referrals, grade promotion, and academic performance data (e.g., test scores and grades). We will not be able to link their school information to their name or to your family.

This information will help DYCD learn how the program helps students and how it can be improved. **Any information we collect will be used only to assess the DYCD program and will not be made public.** The only people who will have access to this information are members of the AIR evaluation team. **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. Participation is voluntary and participants may withdraw at any time. Please contact Deborah Moroney by phone (312-288-7609) or email (dmoroney@air.org) with questions about the study.

If you have concerns or questions about your child's rights as a participant, contact AIR's Institutional Review Board (which is responsible for the protection of project participants) at IRB@air.org, toll free at 1-800-634-0797, or c/o IRB, 1000 Thomas Jefferson St. NW, Washington, DC 20007.

Please select one of the options below:

***Yes**, I GIVE PERMISSION FOR MY CHILD, _____, TO PARTICIPATE in the following:*

☐ *My child WILL complete AIR surveys for SONYC Out-of-School Time Middle School Expansion Evaluation*

☐ *AIR CAN access my child's school information for SONYC Out-of-School Time Middle School Expansion Evaluation. AIR will look at my child's school data such as attendance, disciplinary referrals, grade promotion, and academic performance data however this data is not linked to their name or my family.*

☐ ***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 AIR data collection activities.*

Signature *Date*

For questions about the evaluation, please contact Yael Bat-Chava, ybat-chava@dycd.nyc.gov, 646-343-6237. For all other questions please contact Youth Connect, 1-800-246-4646, or http://www.nyc.gov/html/dycd/html/contact/email_youth.shtml.

DYCD PROGRAM

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** ☐ 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 | District Number __ __ __ | **Phone Numbers** *Home* _____ *Cell* _____ *Work* _____

Health insurance (including Medicaid)? ☐ Yes ☐ No | ☐ **Parent/Guardian** ☐ **Foster Parent** Last Name | First Name

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

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF/Asthma Action Plan):* ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Inhaled corticosteriod ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ **Other** *(specify)* _____

Explain all checked items above or on addendum

Medications *(attach MAF if in-school medication needed)*

☐ None ☐ Yes *(list below)*

_____

_____

Dietary Restrictions

☐ None ☐ Yes *(list below)*

_____

PHYSICAL EXAMINATION

Height _____ **cm** (__ __ %ile)

Weight _____ **kg** (__ __ %ile)

BMI _____ **kg/m²** (__ __ %ile)

Head Circumference *(age ≤2 yrs)* _____ **cm** (__ __ %ile)

Blood Pressure *(age ≥3 yrs)* _____ / _____

General Appearance:

	NI	Abnl		NI	Abnl		NI	Abnl		NI	Abnl		NI	Abnl
☐	☐	HEENT	☐	☐	Lymph nodes	☐	☐	Abdomen	☐	☐	Skin	☐	☐	Psychosocial Development
☐	☐	Dental	☐	☐	Lungs	☐	☐	Genitourinary	☐	☐	Neurological	☐	☐	Language
☐	☐	Neck	☐	☐	Cardiovascular	☐	☐	Extremities	☐	☐	Back/spine	☐	☐	Behavioral

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)* ☐ Within normal limits

If delay suspected, specify below

☐ Cognitive *(e.g., play skills)* _____

☐ Communication/Language _____

☐ Social/Emotional _____

☐ Adaptive/Self-Help _____

☐ Motor _____

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
Hearing ☐ Pure tone audiometry ☐ OAE	__/__/__	☐ Normal ☐ Abnormal
Head Start Only		
Hemoglobin or Hematocrit *(age 9–12 mo)*	__/__/__	_____ g/dL _____ %

	Date Done	*Results*
Tuberculosis *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school*		
PPD/Mantoux *placed*	__/__/__	Induration _____mm
PPD/Mantoux *read*	__/__/__	☐ Neg ☐ Pos
Interferon Test	__/__/__	☐ Neg ☐ Pos
Chest x-ray *(if PPD or Interferon positive)*	__/__/__	☐ NI ☐ Abnl ☐ Not Indicated
Vision *(required for new school entrants and children age 4–7 yrs)*	__/__/__ ☐ with glasses	Acuity *Right* ___ / ___ *Left* ___ / ___ Strabismus ☐ No ☐ Yes

IMMUNIZATIONS – DATES CIR Number of Child

Hep B	__/__/__	__/__/__	__/__/__	__/__/__
Rotavirus	__/__/__	__/__/__	__/__/__	__/__/__
DTP/DTaP/DT	__/__/__	__/__/__	__/__/__	__/__/__
	__/__/__	__/__/__	__/__/__	__/__/__
Hib	__/__/__	__/__/__	__/__/__	__/__/__
PCV	__/__/__	__/__/__	__/__/__	__/__/__
Polio	__/__/__	__/__/__	__/__/__	__/__/__

Influenza	__/__/__	__/__/__	__/__/__	__/__/__
MMR	__/__/__	__/__/__	__/__/__	__/__/__
Varicella	__/__/__	__/__/__		
Td	__/__/__	__/__/__	__/__/__	__/__/__
Tdap __/__/__	Hep A	__/__/__	__/__/__	
Meningococcal	__/__/__	__/__/__		
HPV	__/__/__	__/__/__	__/__/__	
Other, *specify:* _____	__/__/__	_____ ; _____		__/__/__

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet

☐ Restrictions *(specify)* _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: __/__/__

Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision

☐ Other _____

ASSESSMENT ☐ **Well Child** (V20.2) ☐ **Diagnoses/Problems** *(list)* **ICD-9 Code**

_____ __ __ __ __

_____ __ __ __ __

_____ __ __ __ __

Health Care Provider Signature | Date __ __ / __ __ / __ __

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

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (__ __ __) __ __ __ – __ __ __ __ | Fax (__ __ __) __ __ __ – __ __ __ __

DOHMH ONLY **PROVIDER I.D.**

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

Comments

Date Reviewed: __/__/__ **I.D. NUMBER**

REVIEWER:

Copies: **White** School/Child Care/Early Intervention/Camp, **Canary** Health Care Provider, **Pink** Parent/Guardian