



Sunrise of Philadelphia Application Form

***Must be completed and returned before student can begin programming. ***

Sunrise of Philadelphia offers After School/Summer Programs through various funding sources listed above in a Project Based Learning environment.

Please circle the program your child will be participating in:

<p><u>Southwark Elementary and Middle School Programs</u> Located in Southwark Elementary School - Room 108 1835 South 9th Street (9th and Mifflin Streets) Philadelphia, PA 19148 Site Director- Julie Laquer Phone – 215-910-2528</p>	<p><u>Francis Scott Key Elementary and Middle School Programs</u> Located in Key Elementary School - Room ??? 2230 South 8th Street (8th and Wolf Streets) Philadelphia, PA 19148 Site Director- Will Tsang Phone – 267-294-3119</p>
<p><u>Stanton Elementary and Middle School Programs</u> Located in Stanton Elementary School 1700 Christian Street (17th and Christian Streets) Philadelphia, PA 19146 Site Director- Katherine Kushin Phone – 267-666-9847</p>	<p><u>Chester A. Arthur Elementary and Middle School Programs</u> Located in Chester A. Arthur Elementary School 2000 Catherine Street (20th and Catherine Streets) Philadelphia, PA 19146 Site Director- Katherine Kushin Phone –267-666-9847</p>
<p><u>High School Program</u> Located in South Philadelphia High School - Room 311A 2101 South Broad Street Philadelphia, PA 19148 Site Director: Keyonis Johnson Phone – 215-952-2725</p>	

In order for your child to qualify for these programs, we must have your **Full Cooperation**, a **Completed Application**, your **Signed Consent** and current **Child Health Report**. All information is kept confidential under the supervision of the administrative staff of Sunrise. **I hereby agree to the above terms and conditions.**

Parent's Signature

Date

Site Director's Signature

Sunrise of Philadelphia, Inc. follows an equal opportunity policy regarding clients enrolled in our programs. We do not discriminate with regard to race, creed, color, ethnicity, national origin, religion, sex, sexual orientation, gender expression, age, height, weight, or disability status.

Sunrise of Philadelphia Intake Form

Please Print Clearly

Child's Name: _____ Date of Birth: ____/____/____

Home Address: _____ Philadelphia, PA Zip Code: _____

Child's School: _____ Grade as of Sep 2017: _____

School ID Number: _____ Gender: _____

Primary Language Spoken: _____

Caregiver's Name: _____ Relationship to Child: _____

Caregiver's Contact Info: Home/Cell #: _____ Work #: _____

E-mail Address: _____

Child's Race:

African American Asian/Pacific Islander Latino

White Biracial Other (Specify): _____

Child's Special Needs:

Individualized Education Program (IEP) Yes No
(If yes please provide a copy for your child's
file so we can best serve them)

Total Number of People Living in the Home: _____

If you are receiving any benefits, please provide your Case #: _____
and circle the following if they apply:

 Cash Assistance S. S. I. Food Stamps Medicaid No Benefits

Allergies and Asthma

Please list any allergies (including food, medications, etc.) _____

Does your child require an EPI-pen? Circle: **Yes** or **No**

Does your child have Asthma? Circle: **Yes** or **No**

If yes: Is an inhaler needed on site? Circle: **Yes** or **No**

*** Application and enrollment information will be kept strictly confidential!**

EMERGENCY CONTACT / PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124(a)(b), 3270.181 & 182; 3280.124 (a)(b), 3280.181 & 182; 3290.124 (a)(b), 3290.181 & 182

CHILD'S NAME		BIRTHDATE
ADDRESS		
MOTHER'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER
ADDRESS		
BUSINESS NAME		BUSINESS TELEPHONE NUMBER
ADDRESS		
FATHER'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER
ADDRESS		
BUSINESS NAME		BUSINESS TELEPHONE NUMBER
ADDRESS		
EMERGENCY CONTACT PERSON(S)	NAME	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 OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER		TELEPHONE NUMBER
ADDRESS		
SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTION)	
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICATION, SPECIAL CONDITIONS	
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD		
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS		POLICY NUMBER (REQUIRED)
PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT		
OBTAINING EMERGENCY MEDICAL CARE	ADMIN. OF MINOR FIRST - AID PROCEDURES	
WALKS AND TRIPS	SWIMMING	
TRANSPORTATION BY THE FACILITY	WADING	

PERIODIC REVIEW

SIGNATURE OF PARENT or GUARDIAN

DATE

SIGNATURE OF PARENT or GUARDIAN

DATE

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): <input type="checkbox"/> NONE	Date of most recent well-child exam:
Allergies to food or medicine (describe, if any): <input type="checkbox"/> 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	<input checked="" type="checkbox"/> = 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
DTaP/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:

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

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

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 children's 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

Name of Student's OST Provider Agency

Student's Date of Birth

Name of Student's OST Provider Location

Public Health Management Corporation
Out-of-School Time Project

Consent to Collect Information
July 1, 2017 to June 30, 2018

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: Rachel Viddy at PHMC, 215-825-8201 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



Photo Release Form

During the program year, several members of staff take pictures or videos of student activities, projects and events. In addition to using the materials for students' publications and purposes, we occasionally would like to use the pictures or videos in marketing, brochures or other promotional materials. Please read and submit the following release for for your child enrolled at Sunrise of Philadelphia.

Thank you for your prompt attention to this matter.

The undersigned hereby consent to use by Sunrise of Philadelphia my student's name, likeness, picture, photograph, or quotation in all forms and manner for educations, instructional, or promotional purposes without consideration to the undersigned, and I hereby waive any right to inspect or approve the finished version of any written copy that might be used in connection therewith.

- I **GIVE** consent for my child's picture to be taken.
- I **DECLINE** for my child's picture to be taken.

Student's Name: _____

Parent/Guardian Signature: _____ Date: _____