Elmira City School District

New York 21st Century Community Learning Centers
SOARING BEYOND EXPECTATIONS

21ST Century Community Learning Centers (21CCLC)
Student Enrollment Form
School Year _____

STUDENT INFORMATION

Student Name:	Date of Birth:
Grade:	Male _____ Female _____
Address:	City:
State: Zip:	School:
Ethnicity: 1. American Indian/Alaska Native 2. Black/African American 3. Hispanic/Latino 4. Asian 5. White 6. Pacific Islander 7. Other _____	
Language(s) spoken at home:	

PARENT/GUARDIAN INFORMATION

Name of Primary Parent/Guardian 1.	
Guardian Title (circle one) Mother Father Grandmother Grandfather Other _____	
Language(s) spoken at home:	
Home Phone:	Work Phone:
Cell Phone:	Email:
Name of Primary Parent/Guardian 2.	
Guardian Title (circle one) Mother Father Grandmother Grandfather Other _____	
Language(s) spoken at home:	
Home Phone:	Work Phone:
Cell Phone:	Email:

I give my child _____ permission to enroll and participate in the 21st Century Community Learning Centers (21st CCLC) ARCADE Program in Elmira City School District.

_____ _____ _____

(Print) Parent/Guardian Name Parent/Guardian Signature Date

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RELEASE OF CHILD AT DISMISSAL

I would like to have my child ride the bus home: Yes _____ No _____

If no, my child will be picked up after school by me or one of the following 2 individuals:

Name:	Relationship to Student:
Home Phone:	Cell Phone:
Name:	Relationship to Student:
Home Phone:	Cell Phone:

My child ***MAY NOT*** be picked up by the following individuals.

Name:	Relationship to Student:
Name:	Relationship to Student:
Name:	Relationship to Student:

If I am not available during emergencies, my child may be released to one of the following individuals.

Name:	Relationship to Student:
Home Phone:	Cell Phone:
Name:	Relationship to Student:
Home Phone:	Cell Phone:

Parent/Guardian Signature: _____ Date: _____

Elmira City School District

ARCADE PROGRAM
STUDENT HEALTH INFORMATION

Name of Student: _____ Date of Birth _____

School: _____ Grade _____

DISEASE	Y/N	DATE	DISEASE	Y/N	DATE	DISEASE	Y/N	DATE
Chicken Pox			Bee Sting Allergy			High Lead Level		
German Measles			Severe Food Allergy			High Blood Pressure		
Measles			Dizziness w/Exercise			Heart Problems/Murmur		
Mumps			Allergies/Hay Fever			Concussion		
Anemia			Single Testicle			Headaches		
Diabetes			Physical Handicap			Ear Problems		
Seizure Disorder			Rheumatic Fever			Hearing Loss		
Heart Disease			Scarlet Fever			Ankle Injury		
Fainting Spells			Pneumonia			Fracture or Dislocation		
Nose Bleeds			Asthma			Knee Injury		
High Cholesterol			Serious Injuries			Eye Problems		
Spleen Injury			Problem Birth			Vision Loss		
Neck or Back Injury			Operations			Uncorrectable Vision Loss		
Bladder/Kidney Problems			Hospitalization			Glasses or Contact lenses		
Single Kidney								

HEALTH HISTORY – Please explain below any "YES" from above. Use back of page if extra space is needed.

_____

_____

Family Doctor: _____ Phone: _____

Address: _____

Is your child taking any medications? Yes:___No: ____Please list medications: _____

_____

_____

Will your child be taking any medications during the time of the ARCADE program? Yes:_____ No: _____

If yes, please speak to school nurse.

Does your child have any allergies (do not include hay fever)? _____

_____

Does your child have any activity restrictions? Yes ___ No ___

If so, please explain? _____

Parent/Guardian Signature: _____ Date: _____

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Consent to Photograph, Film, or Videotape a Student for Non-Profit Use
(e.g. Educational, Public Service or Health Awareness Purposes)

Student Name: _____ School:_____

I hereby consent to the participation in interviews, the use of quotes, and the taking of photographs, movies or videotapes of the student named above by: _____ _____. I also grant to _____ the right to edit, use, and reuse said products for non-profit purposes including use in print, on the internet, and all other forms of media. I also hereby release _____ _____ and its agents and employees from all claims, demands, and liabilities whatsoever in connection with the above.

_____ _____

(Print) Parent/Guardian Name Date

_____

(Signature) Parent/Guardian Name

_____

Address of Parent / Guardian City State Zip

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Student Data and Evaluation Consent Form

Your child, _____, is enrolled in the program funded by the 21st Century Community Learning Center grant (21st CCLC). In order to monitor the effectiveness of the program and ensure its future success, an independent evaluator is conducting an ongoing evaluation. It is the intentions of the evaluation to learn how these services help students, and how they can be improved in order to meet the grant requirements.

Specifically we ask permission to:

- Obtain demographic data including: racial/ethnic group, gender, grade level, English proficiency, free or reduced price lunch eligibility, and special needs from the New York City Department of Education for students in the 21st CCLC program.
- Contact your child's school to obtain records showing his or her progress, including information about enrollment, grades, citywide and statewide test scores, and 21st CCLC program attendance.
- Survey and/or interview you and your child about the 21st CCLC program and its effects.
- Talk to teachers and staff about your child's progress and participation in the 21st CCLC program, and review program records on participation in the program.

Individual student data we collect will only be used to assess the 21st CCLC program and will not be made public. Participating in the evaluation will not affect your child in school, in the 21st CCLC 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 evaluation, we will destroy all records that include personal information. Participation in the study in 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 program coordinator/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 the evaluation of the 21st CCLC program. I also consent for the evaluator and _____ to obtain my child's records, interview program and school staff, and interview me and my child for evaluation purposes.

_____ 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 evaluation of the 21st CCLC program.
If at any time you change your mind about your decision, please contact your site coordinator.

_____	_____	_____
Student Name	School	Date
_____	_____	
(PRINT) Parent/Guardian Name	(SIGNATURE) Parent/Guardian Name	