2018 - 2019

Youth Arts Workshop

After-school Arts Program for Grade 6-8

Every weekday 3:30-6:00pm
Starting September 10th 2018
Fun and educational activities
Art supplies provided
Snacks Provided
Monthly Field Trips

This school year, we will use bookmaking as a tool to tell stories about identity, community, and social justice. We will learn about different bookmaking skills from zine-making to hand-binding as well as many other fun studio activities.

Contact: Jiawen@AsianArtsInitiative.org or 215 557 0455 for more information.
**YA Registration Form**

**General Student Information**

<table>
<thead>
<tr>
<th>Student's Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>School</th>
<th>Date of Birth</th>
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<td><em><strong>/</strong></em>/___</td>
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</table>

<table>
<thead>
<tr>
<th>Student ID # (For Public and Charter Only)</th>
<th>Grade</th>
</tr>
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<table>
<thead>
<tr>
<th>Name of Parent/Guardian/Primary Contact</th>
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</table>

<table>
<thead>
<tr>
<th>Home Address</th>
<th>Zip Code</th>
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</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Home Phone #</th>
<th>Phone #</th>
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<tr>
<td><em><strong>-</strong></em>-<em><strong>-</strong></em></td>
<td><em><strong>-</strong></em>-<em><strong>-</strong></em></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Parent/Guardian/Primary Contact's Email address</th>
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</tbody>
</table>

**Demographic Information**

- Student's Race-Ethnicity (Check all that apply)
  - Hispanic/Latino of any Race
  - American Indian or Alaska Native
  - Asian
  - Black or African American
  - Native Hawaiian or Other Pacific Islander
  - White or Caucasian
  - Two or more races
  - Other

<table>
<thead>
<tr>
<th>Student's Gender</th>
<th>Prefer to Self-Describe:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
</tr>
<tr>
<td>Non-Binary/Third Gender</td>
<td></td>
</tr>
<tr>
<td>Prefer not to Say</td>
<td></td>
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</tbody>
</table>

**Dismissal Information**

For parent/guardian pick-ups, you must provide the information requested in full.

- Student will walk to/from program
- Student will take bus to/from program
- Student will take subway to/from program
- Student will take regional rail/train to/from program
- Student will be dropped off and/or picked up by an adult to/from program

If student is being dropped off and/or picked up, student will be picked up daily by

<table>
<thead>
<tr>
<th>Phone number: <em><strong>-</strong></em>-___</th>
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</thead>
<tbody>
<tr>
<td>Relation to student:</td>
</tr>
</tbody>
</table>

**Liability Agreement:**

- By checking this box, you acknowledge that once a student has been dismissed and signed out of program, Asian Arts Initiative is no longer liable for the student.
In order to participate in Youth Arts Workshop Out-of-School-Time program, the student is required to complete and submit their Report of Physical Examination. By signing the line below, you understand that this form must be completed and submitted to the Youth Programs Manager no later than 30 days after enrollment.

(Parent/Guardian Signature)

**PERMISSION**

By checking off the boxes in this section, you are consenting and agreeing to each of the statements.

<table>
<thead>
<tr>
<th>I authorize the following for my child:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ To participate in Asian Arts Initiative’s Youth Arts Workshop Out-of-School-Time program</td>
</tr>
<tr>
<td>☐ To participate in field trips to museums, parks, etc.</td>
</tr>
<tr>
<td>☐ To participate in evaluation activities of the program</td>
</tr>
<tr>
<td>☐ To have her/his likeness and/or voice to be recorded for any use by television, films, radio, web pages, or printed media to further Asian Arts Initiative’s Program in related campaigns, articles, booklets, posters, and in any other way they see fit</td>
</tr>
</tbody>
</table>

I hereby authorize officials of the School District of Philadelphia or my child’s school to release my child’s educational records (limited to: standardized tests, graduation and promotion information, grades, credits, attendance information, school status and copies of report cards) only to Asian Arts Initiative. This consent will last until I/my child is no longer enrolled in an Asian Arts Initiative-sponsored activity or until I rescind this consent in writing.

I understand that this information will not be provided to any entity other than those indicated above. I understand that a record will be maintained in my child’s educational records, indicating that the information was provided. I understand that I may acquire a copy of this record, as well as of any records provided to Asian Arts Initiative, from the School District of Philadelphia or my child’s school.

I hereby release and fully discharge Asian Arts Initiative from all claims, liabilities, obligations, causes of action, or demands that I or my administrators, executors, heirs, and assignees may have or obtain due to or as a result of personal bodily harm sustained or suffered as a result of any field trips or program activities.

<table>
<thead>
<tr>
<th>Print Parent/Guardian Name</th>
<th>Relationship to Student</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian Signature</td>
<td>Date</td>
</tr>
</tbody>
</table>
# EMERGENCY CONTACT / PARENTAL CONSENT FORM

**CHILD'S NAME**

**ADDRESS**

**MOTHER'S NAME/LEGAL GUARDIAN**

**ADDRESS**

**BUSINESS NAME**

**ADDRESS**

**FATHER'S NAME/LEGAL GUARDIAN**

**ADDRESS**

**BUSINESS NAME**

**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**

**ADDRESS**

**TELEPHONE NUMBER**

**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**

**WALKING**

**PERIODIC REVIEW**

---

**SIGNATURE OF PARENT or GUARDIAN**

**DATE**

---

**SIGNATURE OF PARENT or GUARDIAN**

**DATE**

**ORIGINAL**
Child Health Assessment

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

Allergies to food or medicine (describe, if any):

☐ NONE

Do not omit any information. This form may be updated by health professionals. (Initial and date new data.) Child care facility needs 2 copies.

LENGTH/HEIGHT  WEIGHT  HEAD CIRCUMFERENCE  BLOOD PRESSURE

<table>
<thead>
<tr>
<th>IN/CM % ILE</th>
<th>LB/KG % ILE</th>
<th>IN/CM % ILE</th>
</tr>
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<tr>
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</tr>
</tbody>
</table>

PHYSICAL EXAMINATION  = NORMAL

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  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:

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.

Parents & Child Care Providers fill-in this part.
Public Health Management Corporation
Out-of-School Time Project

Consent to Collect Information
July 1, 2018 to June 30, 2019

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: 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 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 ___________________________
I. IDENTIFYING INFORMATION FOR “SERVICES FOR NON-PLACED CHILDREN”

1. CHILD’S NAME (LAST, FIRST, M.I.)  
2. SEX: ☐ MALE ☐ FEMALE

3. CHILD’S DATE OF BIRTH  
4. CHILD’S SSN

5. COUNTY IDENTIFIER

6. PERSON WITH WHOM THE CHILD IS LIVING  
7. RELATIONSHIP TO CHILD

8. SSN OF PERSON WITH WHOM CHILD IS LIVING

9. AGENCY NAME  
10. 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 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

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

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: _____________

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

7. Date this form was completed: _____________
## 400% MEANS TEST WORKSHEET

### I. IDENTIFYING INFORMATION FOR “SERVICES FOR NON-PLACED CHILDREN”

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<tbody>
<tr>
<td>12.</td>
<td>CHILD'S NAME (LAST, FIRST, M.I.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>SEX:</td>
<td>MALE</td>
<td>FEMALE</td>
</tr>
<tr>
<td>14.</td>
<td>CHILD’S DATE OF BIRTH</td>
<td></td>
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<tr>
<td>15.</td>
<td>CHILD’S SSN</td>
<td></td>
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</tr>
<tr>
<td>16.</td>
<td>COUNTY IDENTIFIER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>PERSON WITH WHOM THE CHILD IS LIVING</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>RELATIONSHIP TO CHILD</td>
<td></td>
<td></td>
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<tr>
<td>19.</td>
<td>SSN OF PERSON WITH WHOM CHILD IS LIVING</td>
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<tbody>
<tr>
<td>20.</td>
<td>AGENCY NAME</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>PROGRAM NAME</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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

<p>| | | | |</p>
<table>
<thead>
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<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
</tr>
<tr>
<td></td>
<td>400% of FPL (Gross Annual)</td>
<td>400% of FPL (Gross Monthly)</td>
<td>(YES or /NO)</td>
</tr>
<tr>
<td>1</td>
<td>Less than $41,600</td>
<td>Less than $3,460</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Less than $56,000</td>
<td>Less than $4,667</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Less than $70,400</td>
<td>Less than $5,867</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Less than $84,800</td>
<td>Less than $7,067</td>
<td></td>
</tr>
</tbody>
</table>

Note: For family units of more than 4 members, add $14,400 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: ______________________