

Office of Youth Services

Application for (please circle one): **S.O.A.R. I - S.O.A.R. II - SAFE HAVEN - BUILDING FUTURE LEADERS**

PLEASE PRINT NEAT & LEGIBLE

Child's Name: _____

Child's Home Address: _____ Home Phone: _____

Sex: F _____ M _____ Date of Birth: ____/____/____ Grade: _____ Age: _____

Mother's/Guardian's Name: _____ Father's Name: _____

Mother's Work Place: _____ Father's Work Place: _____

Mother's Work #: _____ Father's Work #: _____

Mother's Pager/Cellular Phone: _____ Father's Pager/Cellular Phone: _____

MANDATORY THREE EMERGENCY CONTACTS: Three local people to be called if student is ill or injured and parents are unavailable. **These people have parents permission to take responsibility for the child, and to take him/her home.** If any information is found to be false or phone #'s are not working or disconnected, your child will be dismissed from the program until the correct information is provided!

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

Parent Information

This section is for our records and will remain confidential.

1. Are you the parent ___ yes ___ no **or** the guardian ___ yes ___ no of the child?
2. If you are the Guardian, what is your relationship to the child if any: _____
3. Your age: ___ 18-23 ___ 24-29 ___ 30-35 ___ 36-40 ___ 41-45 ___ 46-50 ___ 51-55 ___ over 56
4. Number of children enrolled in this program _____
5. Total number of living children _____
6. Marital Status: ___ Married ___ Single ___ Divorced ___ Widowed
7. Family Income: ___ \$15000-20000 ___ \$21000-25000 ___ \$26000-30000 ___ \$31000 & over
8. Primary source of income: _____
9. Highest grade completed: ___ High School ___ GED ___ College ___ Other (list) _____
10. Ethnic background: ___ African American ___ White (not of Hispanic origin) ___ Hispanic ___ Haitian ___ Portuguese ___ Other please indicate: _____

Consent

I hereby release the City of Elizabeth, the Officers, Directors and Employees of participating agencies, the Elizabeth Board of Education and/or businesses from any liability whatsoever arising out of the transport and/or participation of my child in this program. This Includes, but is not limited to, claims and expenses incurred in traveling to and from any destination.

I have read, understand and accept the above.

Parent/Guardian

Signature: _____ **Date:** _____

MEDICAL INFORMATION FORM

PLEASE PRINT NEAT & LEGIBLE: This form must be completed in its entirety, please complete and return to the Office on Youth or program site.

Child Name: _____

Sex: F ___ M ___ Date of Birth: ___/___/___ Grade: _____

Mother/Guardian's Name: _____

Father's Name: _____

Home Address: _____

Home Phone: _____ Cellular Phone: _____

CHILD'S PREFERRED SOURCE OF MEDICAL CARE

Physician's Name: _____ Phone: _____

Dentist Name: _____ Phone: _____

Hospital: _____ Phone: _____

Does your child have any allergies to:

Medication: Yes ___ No ___ **Food:** Yes ___ No ___

Other Substances: Yes ___ No ___ If yes, please explain: _____

Does your child wear glasses or contacts? Yes ___ No ___

Does your child require prescribed medication? Yes ___ No ___ If yes, please explain (**include dosage, schedule and duration**): _____

Does your child have a history of:

Asthma/Breathing Problems: Yes ___ No ___ Diabetes: Yes ___ No ___

Epilepsy/Convulsion/Seizures: Yes ___ No ___ Sickle Cell Anemia: Yes ___ No ___

Heart Trouble: Yes ___ No ___ Fainting Spells: Yes ___ No ___ or other, if yes, please explain: _____

Does your child have any other special health problems we should know about?

Yes ___ No ___ If yes, please explain: _____

May your child participate in all physical activities? Yes ___ No ___ If no, please explain, (**doctor's note may be needed**): _____

IF YOUR CHILD HAS ANY PHYSICAL RESTRICTIONS AND MUST TAKE MEDICATION WHILE ATTENDING THE PROGRAM, YOU MUST SEE THE NURSE.

Office of Youth Services

AUTHORIZATION TO ADMINISTER MEDICATION IN SCHOOL [TO BE KEPT CONFIDENTIAL UPON COMPLETION]

Name of Student _____ Age _____ D.O.B. _____

Diagnosis/Illness _____

Medication _____ Dosage _____ Frequency _____

Special Directions _____

Possible Side Effects

I certify that the above information regarding this student is correct, and that administration of the medication to this student is necessary.

[Signature of Prescribing Physician]

[Date]

[Address]

[Phone]

I/We authorize the Office on Youth Nurses to administer the above medication as indicated. I/We understand and agree that the Office on Youth including the programs, the Nursing Staff and the Program Coordinators shall not be liable for any injury to the student resulting from the administration of the medication as authorized by my signature below.

[Signature of Parent/Guardian]

[Signature of Parent/Guardian]

[Date]

RELEASE

AS THE PARENT OR LEGAL GUARDIAN OF _____,
(Print Child's Name)

I GIVE THE "OFFICE ON YOUTH SERVICES" PERMISSION TO ALLOW MY CHILD TO RETURN HOME WITHOUT AN ESCORT. BY SIGNING THIS RELEASE, I HEREBY RELEASE THE CITY OF ELIZABETH, ITS EMPLOYEES, AGENTS AND/OR SERVANTS, PARTICIPATING AGENCIES, THE ELIZABETH BOARD OF EDUCATION, AND/OR BUSINESSES, FROM ANY LIABILITY WHATSOEVER ARISING OUT OF MY CHILD TRAVELING ALONE FROM THE "OFFICE OF YOUTH SERVICES" PROGRAMS

NO, I DO NOT WANT MY CHILD TO WALK HOME. I WILL PROVIDE AN ESCORT.

YES, I DO AUTHORIZE MY CHILD TO WALK HOME

Dated: _____

(Signature of Parent/Guardian)

(Print/Type Name of Parent/Guardian)

Child's Address

Phone Number

RELEASE

RE: _____
(Print Child's Name)

IN CONSIDERATION FOR BEING ALLOWED TO PARTICIPATE IN "OFFICE OF YOUTH SERVICES" I HEREBY RELEASE "THE OFFICE OF YOUTH SERVICES" FROM ANY LIABILITY FOR PAYMENT OR OTHER COMPENSATION FOR THE USE OF MY CHILD'S PICTURE OR LIKENESS, VOICE, BIOGRAPHICAL INFORMATION, OR OTHER MATERIAL PROVIDED TO THE "OFFICE OF YOUTH SERVICES". I ALSO AGREE TO ALLOW THE "OFFICE OF YOUTH SERVICES" TO USE THESE MATERIALS AS IT SEES FIT, INCLUDING ADVERTISING AND/OR PUBLIC RELATIONS.

Dated: _____

(Signature of Parent/Guardian)

(Print/Type Name of Parent/Guardian)

Child's Address

Phone Number

PLEASE LOOK OVER ENTIRE APPLACATION TO ENSURE COMPLETEION.