The Arc
York & Adams Counties

AFTER SCHOOL PROGRAM
2024-2025

APPLICATION / EMERGENCY INFORMATION FORM

Student's Name _____ Age _____
Address _____
Street City State Zip

Date of Birth _____ School District Attending _____
Class in School _____ Teacher _____
MH/IDD Case Manager _____Phone #_____

Mother's (Guardian's) Name _____ Phone # _____
Address _____
Street City State Zip
Place of Employment _____ Phone # _____
Work Address _____
Street City State Zip
Work Hours _____ Email address _____

Father's Name _____ Phone # _____
Address _____
Street City State Zip
Place of Employment _____ Phone # _____
Work Address_____
Street City State Zip
Work Hours _____ Email address _____

Person to contact in an emergency: If parents cannot be reached, who is familiar with member and is available from 2:30 PM - 6:00 PM.?
Name _____ Phone # _____
Address _____
Street City State Zip

Student's Physician
Name _____ Phone # _____
Address_____
Street City State Zip
Hospital _____

Health Insurance or PA Medical Assistance (ACCESS)
Name of Company _____ Recipient Name _____
Policy # _____
Group # _____
Individual Number # _____

STUDENT'S
DIAGNOSIS:_____

SPECIAL DISABILITY INSTRUCTIONS (please be specific)

Special disability, medical or dietary information necessary for management in an emergency - allergies, medications, seizures, _____
_____
_____

Medication(s)

Please list any medications the member takes on a regular basis.

Name of medication	**Dosage**	**Time**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

While attending the After-School Program, I give permission to staff to use their own judgment in administering the following if needed:
_____ Tylenol _____ (indicate amount)
_____ Advil (Ibuprofen) _____ (indicate amount)
_____ Triple Antibiotic Ointment

Please list all persons to whom student may be released. Students will NOT be released to anyone else without notification from parent (s) / guardian and proof of identity upon picking up student.

_____ _____
_____ _____
_____ _____

If emergency treatment is required, I give my consent for the After-School Options Program staff to send _____ to the hospital most quickly accessible and I will be responsible for any medical fees incurred by such an emergency

_____ _____
Parent/Guardian Signature Date

I&F: Aftrschl:2017AllDoc22/18

HEALTH EXAMINATION BY LICENSED PHYSICIAN

Student's Name _____ Date: _____

I _____ authorize my Physician to provide the following
Parent/Guardian
Information.
I understand that it will be used only by The Arc of York & Adams Counties staff to care for my child.

Signature _____ Date _____

All information is to be completed by a licensed physician.

I have examined the above person within the past year.
Date of Exam: _____

Is the person free of infectious diseases? Yes_____ No_____
If no, please indicate type of disease
_____

Medication(s) prescribed and dosage(s):

Medication	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medical information pertinent to diagnosis and treatment in case of an emergency:
_____
_____
_____

Recommended modifications or limitations of applicant's activities or diet:
_____
_____

Is there any medical reason that this person should not participate in an after school activity which may include swimming, basketball, exercise machines, weight lifting, games, crafts, and computers?

_____ YES _____ NO

If yes, please elaborate.

_____

_____

_____

The Arc
York & Adams Counties

IMMUNIZATIONS

Vaccines	Dates given
DTP: Diphtheria-Tetanus-Pertussis	1. 4. 2. 5. 3. 6.
TOPV Trivalent Oral Polio	1. 4. 2. 5. 3.
Measles	1. 2.
Mumps	1. 2.
Rubella	1. 2.
HIB Haemophilus	1. 2.
Hep B Hepatitis B	1. 2.
Tuberculin test	

Form completed by _____

For/ by Dr. _____
Please type or print

Licensed Physician's Signature

_____

Telephone: _____

Address:

_____
Street City State Zip

Date form completed _____

The Arc
York & Adams Counties

AGREEMENT

This agreement is between The Arc of York & Adams Counties and the parents of _____ in order for him/her to attend the After-School Options Program. This agreement remains in effect as long as he/she is enrolled in the program.

The After-School Options Program agrees to:

1. Provide day care services from 2:30 PM - 6:00 PM, Monday through Friday, on days that schools are in session.
2. Provide a safe and appropriate physical site and program.
3. Provide supervision of students enrolled.
4. Hire qualified staff that have proper criminal and child abuse clearances.
5. Keep all records confidential and release information to other parties only upon written consent of the parent(s) in accordance with HIPAA.
6. Keep emergency information on hand at all times; provide emergency medical care when needed; in case of an emergency, notify parent or emergency contact person as soon as possible; and accompany student to the emergency center and remain with the student until the parent(s) or designee assumes responsibility.
7. Provide a variety of activities – fun, learning.
8. Provide snacks and rest as student needs.
9. Release the student only to those persons designated in writing by the parent(s)/guardian(s).
10. Provide after school services starting at an earlier time for regularly scheduled early dismissals from school when staffing allows.
11. **Weather related emergency dismissals**- The After-School Options Program agrees with the school districts' decision that students are to go home when school dismisses early for these emergencies.

The parent(s)/guardian(s) agree to:

1. Supply all information and records as required for the program.
2. Pick up the member or arrange for transportation home **by 6:00 PM**. Parents will be billed $5.00 for every 15 minutes they are tardy, beginning at 6:15 pm. This money will come from their personal finances, not YAC MH/IDD.
3. Notify the After-School Options Program of any changes in address, telephone number, or emergency information.
4. Notify the After-School Options Program if the member will not be attending on a particular day.
5. Notify the After-School Options Program of any early dismissals (holiday schedules, in-service days, etc.) other than weather related emergencies so we can arrange for staff to be available.
6. Keep the member home if they are too sick to be around the other students.
7. **MAKE ARRANGEMENTS FOR THE MEMBER TO GO HOME WHEN THE SCHOOL DISTRICT ANNOUNCES EARLY DISMISSAL DUE TO WEATHER OR OTHER EMERGENCIES.**

_____ _____

(Signature of After School Options Coordinator) Date (Signature of Parent(s)/Guardian(s) Date

LIABILITY RELEASE

We, the parents/guardians of

_____
(Print Name)

Hereby give permission to have our child actively participate in the various activities that will be a part of the After-School Options Program, sponsored by The Arc of York & Adams Counties. These activities may occur at either the Lutheran Memorial Church or other community business. The activities include but are not limited to - arts and crafts; games; music; dancing; sports.

Absent gross negligence or wrong doing by The Arc of York & Adams Counties, Inc., (or its affiliates) or its staff, we hereby release The Arc of York & Adams Counties; the Lutheran Memorial Church, the After School Options Program, staff, volunteers, and any and all other persons who assist in taking charge of the said programs and activities from any and all liability or claim rising from the accidental injury to, or death of, our child incurred during or in transit to or from our child's participation in programs and activities from any cause whatsoever.

We further waive claim on The Arc of York & Adams Counties, and the Lutheran Memorial Church for any loss or damage to my child's property, whether at the church, or en-route to and from the site.

Intending to be legally bound hereby, we set our signatures below.

_____
(Signature of Parent/Guardian) (Date

_____
(Signature of Parent/Guardian) (Date)

RELEASE OF INFORMATION

I / We, _____
(Name of parent / guardian)

Authorize

_____ ,

_____ ,
(Name of the School Your Child Attends)

And _____ as well as York County
(List any other support agencies you feel we may need to contact, such as wrap-around agencies.)

MH-IDD, to release information to The Arc of York & Adams Counties in order to optimize care on behalf of _____.
(Name of Student)

This information may include copies of assessment documents including psychological evaluations, treatment plans, medical reports, current Individual Education Plans, and teacher interviews. This information will remain confidential.

_____ _____

(Signature of Parent/Guardian) (Date)

TRANSPORTATION RELEASE

_____ will be attending The Arc of York & Adams Counties
(Name of Student)

After School Options Program beginning on the following date _____
(First Day of Transportation)

The Lincoln Intermediate Unit # 12 (LIU) or their sub-contractors has my permission to transport my child to Lutheran Memorial Church, 1907 Hollywood Drive, York, PA 17403 (Next to York Suburban High School) on a daily basis after school.

_____
(Signature of Parent or Guardian) (Date)

Note: Parents need to make arrangements with Rabbittransit if your child will be using Rabbittransit vans to go home from the After-School Options Program.

I& F: Aftrschl:2017AllDoc22-2018

PHOTOGRAPHY RELEASE

I give my permission for photographs of my child at the After School Options Program to be published in the local newspapers or other media or in the newsletter of The Arc of York County.

_____
(Signature of Parent/Guardian) (Date)

THE ARC OF YORK & ADAMS COUNTIES HOUSEHOLD SURVEY

The Arc of York County receives contributions and funding from many sources, including United Way and the County of York. They have requested that we collect the following information. It is not mandatory for you to complete this form, but it will be appreciated as it will help The Arc receive much needed funding.

1. Please check the gender of the person(s) who will receive Arc services.
   _____ Female _____ Male

2. Please check the age range of the person(s) who will receive Arc services.
   0-5 _____ 6-8 _____ 9-14 _____ 15-18 _____ 19-21 _____ 22-61 _____ 62+ _____

3. Is the person who receives Arc services Hispanic/Latino?
   _____ Yes _____ No

4. Please check which <u>one</u> racial description best fits the person who receives Arc Services: **(Check one only)**

Single Race		**OR**	**Multi-Race**	
White			Black or African American AND White	
Black or African American			Asian AND White	
Asian			American Indian or Alaska Native AND White	
American Indian or Alaska Native			American Indian or Alaska Native AND Black or African American	
Native Hawaiian or Another Pacific Islander			Another Multi-Race	

5. Please indicate the total number of persons currently residing in your household. _____

6. Please check which of the following describes your family's "head of household." **(Check only one.)**
   _____ Male _____ Female _____ Two Parents

7. What is your total yearly family income from wages or salary, self-employment, social security? Pension, public, assistance, rent, interest, or other sources? (Check one line only.)

_____ $ 0---11,250	_____ $21,251---21,450	_____ $35,401---38,600
_____ $11,251---12,850	_____ $21,451---24,100	_____ $38,601---42,900
_____ $12,851---14,450	_____ $24,101---26,800	_____ $42,901---46,300
_____ $14,451---16,100	_____ $26,801---28,950	_____ $46,301---49,750
_____ $16,101---17,350	_____ $28,951---30,000	_____ $49,751---53,150
_____ $17,351---18,650	_____ $30,001---31,100	_____ $53,151---56,600
_____ $18,651---18,750	_____ $31,101---33,250	_____ 56,601 & over
_____ $18,751---19,950	_____ $33,251---34,300	_____ Unknown
_____ $19,951---21,250	_____ $34,301---35,400	

8. Please list the places of employment for all members of your household.

_____

_____

9. Name of Individual Receiving Services _____
   Address _____

   Signature of Person completing Form _____

Please complete this form and return it to: The Arc of York & Adams Counties
497 Hill Street
York, PA 17403

Revised 6/27/17

This information will be kept strictly confidential. Thank you.

Parent Transportation Agreement

After School Options

I hereby give permission for an employee of The Arc of York & Adams Counties, to transport my child(ren) for the purposes of the After School program.

It is agreed that:

1. The Arc employee will never leave my child(ren) unattended in any motor vehicle or other form of transportation.

2. Each child will board or leave a vehicle from the curb side of the street.

3. My child(ren) will be secured in safety seats or by safety belts as appropriate for the age of the child(ren) in accordance with the law.

4. Any motor vehicle used to transport my child(ren) will have current registration and insurance, and must be operated by a person who is at least 18 years of age and possesses a valid driver's license.

_____
Child's Name

_____ _____
Parent or Guardian Date

_____ _____
Driver Date