As soon as your child has been enrolled and accepted into the Community Learning Center After School Program, you will be notified by the Program Manager by phone. **A parent, guardian or responsible adult must come to a mandatory program orientation** before a registered child can attend program. We will call you to set up a time for orientation once your application has been received and processed.

**Program starts 9/7/2022 to 6/2/2023**

**Program Contact Person Information:**

**Tarlon Gibson**
Office: 585-288-0021  
Cell: 585-435-9347  
Fax: 288-8662  
Email: tgibson@communityplace.org  
145 Parsells Avenue  
Rochester, New York 14609
Community Learning Center
Registration Application 2022-2023

After School Program
9/7/22-6/2/2023
Monday-Friday 2pm-6pm

Serving Grades:
Kindergarten – 8th grade

Located at:
145 Parsells Ave
Rochester, NY 14609

Important Notes:
Incomplete registrations will not be accepted.

There will be a Mandatory Parent Orientation Prior to the Start of Program

Registrations are only accepted Monday’s – Thursday’s.

Office Use Only:
Date Received:  
Received By:  
Date Entered:  
Entered By:  

Page 1 of 8
Child’s Name: ______________________________________

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>Zip Code</th>
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<tr>
<th>Date of Birth</th>
<th>Race/Ethnicity</th>
<th>Gender</th>
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<td>☐ Male ☐ Female</td>
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<tr>
<th>School</th>
<th>Grade</th>
<th>RCSD ID # (Required - Found on Report Card)</th>
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<tr>
<th>Parent/Guardian Name</th>
<th>Relationship to Child</th>
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<th>City</th>
<th>Zip Code</th>
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<th>Home Phone</th>
<th>Cell Phone</th>
<th>Work Phone</th>
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<th>Employer</th>
<th>E-mail Address</th>
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<tr>
<th>Parent/Guardian Name</th>
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<th>E-mail Address</th>
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So we can identify families, if you are registering siblings please list their names and their grade 2022/2023

*One Application Per Child*

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<thead>
<tr>
<th>Name:</th>
<th>Relationship:</th>
<th>Grade:</th>
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<tbody>
<tr>
<td>Name:</td>
<td>Relationship:</td>
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<td>Name:</td>
<td>Relationship:</td>
<td>Grade:</td>
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Page 2 of 8
The Youth Plan is a service plan for youth engaged in The Community Place of Greater Rochester’s Community Learning Center (CLC). The goal of the Community Learning Center is to prepare youth for college, work, and life by age 21 through innovative and engaging after-school programming activities, workshops, and field trips. Programming focuses on the following core components of youth development and enrichment:

1. Academic Enrichment (Literacy, STEM, and HW Assistance)
2. College and Career Exploration
3. Civic Engagement and Community Service Learning
4. Health and Physical Fitness
5. Social and Emotional Development
6. Leadership and Character Development
7. Artistic and Cultural Development

Youth participants agree to:
- Actively participate in scheduled activities each day and for at least 3 days a week.
- Work towards successfully implementing and achieving Youth Behavioral Guidelines of program.

CPGR Staff agrees to:
- Create a welcoming, friendly, and safe environment for youth participants and their families.
- Deliver quality program incorporating core components of youth development and enrichment activities.
- Provide age appropriate activities, use evidence based curriculums and include youth voice/choice in program offerings.
- Interact with youth establishing rapport and making appropriate referrals for wrap around services as needed.
- Contact parent/guardian about their child’s successes in program and when challenges arise.

Parent/Guardian agrees to:
- Support all staff, partners, and volunteers involved with helping youth to be successful.
- Be an active participant in programming through attending events, conversations with staff, completing satisfaction surveys, reading newsletters, etc.
- Communicate with Community Learning Center staff regarding program absences, changes in contact information, health concerns, and behavior concerns.
- Provide honest feedback on the Community Learning Center to facilitate the continuous improvement of the program to meet the needs of families.

Youth Signature ___________________________ Date __________

Parent Signature ___________________________ Date __________

Staff Signature ___________________________ Date __________
Privacy Notice – Acknowledgement of Receipt

New federal regulations require The Community Place of Greater Rochester, Inc. (CPGR) to send a Privacy Notice to everyone who receives services from CPGR. These regulations are known as the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The HIPPA Privacy rule does not change the way you receive services from CPGR. It does not change the privacy rights you have had under New York State Mental Hygiene law. The HIPPA privacy rule requires CPGR to take some additional steps to make sure you are aware of your privacy rights.

By signing this acknowledgement form, I am confirming that:

- I have received a copy of CPGR’s Privacy Notice.
- I understand that I can contact people listed in the Privacy notice to get more information about my privacy rights at CPGR.

Participant name (please print): ________________________________

Parent/Guardian name: ________________________________

Parent/Guardian Signature: ________________________________ Date ________________________________

In the event the participant and/or his/her guardian is unable to comprehend the notice:

Address of contact person: ________________________________

Signature of Contact Person: ________________________________ Date ________________________________

Relationship to consumer: ________________________________
All Combined Releases: Please read carefully and sign accordingly.

1. **SCHOOL RELEASE:** The Community Place of Greater Rochester is working with parents and schools to monitor and improve school attendance rates and grades as well as to foster greater commitment to education among youth program participants from Kindergarten to 8th grade. In order for us to accomplish these goals, we need your permission to both obtain from and give information to your child’s school. If you have any questions about the program, please feel free to call Tarlon Gibson, Director of Early Childhood and Youth Development, at (585)288-0021. I agree to let the Community Place of Greater Rochester, Inc. (CPGR) obtain and/or give information to

   ___________________________ about ___________________________
   ((Child’s School))                               ((Child’s Name))

   I have read and support the information above and by signing below I give my permission for the release of information.

   ___________________________                        ___________________________
   Parent/Guardian Signature                                  Date

2. **IMAGE RELEASE:** I give permission for my child to be photographed / videotaped for promotional purposes while participating in this program.

   ___________________________                        ___________________________
   Parent/Guardian Signature                                  Date

3. **PROGRAM TRANSPORTATION:** I give the Community Place of Greater Rochester, Inc. permission to transport my child for scheduled field trips and program outings.

   ___________________________                        ___________________________
   Parent/Guardian Signature                                  Date

4. **PERMISSION TO PARTICIPATE IN PROGRAM EVALUATION:** The Community Place of Greater Rochester is committed to providing the best possible program for youth and families and making sure that the program is effective in preparing youth for employment, life and college. We will be using various methods to evaluate program success, including parent/youth surveys, focus groups, assessment tools, etc. All information will be kept strictly confidential. I give my child permission to participate in Program Evaluation activities.

   ___________________________                        ___________________________
   Parent/Guardian Signature                                  Date

5. **MEDICAL RELEASE:** I give permission that my child, may be given first aid and emergency treatment by a child care provider of the Community Place of Greater Rochester, Inc.’s Community Learning Center. This includes minor first aid, sunscreen, antihistamine cream and antibiotic cream

   ___________________________                        ___________________________
   Parent/Guardian Signature                                  Date

6. **PROGRAM RELEASE:** I give my permission for my child to participate in the Community Place of Greater Rochester’s Community Learning Center.

   ___________________________                        ___________________________
   Parent/Guardian Signature                                  Date
Child’s Name: ________________________________

Does your child receive any of the following through school? Please check box for Yes Leave Blank for No. **(Required)**

<table>
<thead>
<tr>
<th>Special Education</th>
<th>Special Needs</th>
<th>IEP</th>
<th>Limited English Proficiency</th>
<th>Free/Reduced Lunch</th>
</tr>
</thead>
<tbody>
<tr>
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**Child Health Information**

<table>
<thead>
<tr>
<th>Special Health Problems:</th>
<th>☐ Yes ☐ No (Ex. ADD, ADHD, Emotional, Psychological) If Yes, please specify.</th>
<th>Allergies (Food, Drug, Environmental):</th>
<th>☐ Yes ☐ No If Yes, please specify.</th>
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<table>
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<tr>
<th>Regular Medications?</th>
<th>☐ Yes ☐ No If Yes, please specify.</th>
<th>Important information we should know about your child...</th>
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<table>
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<tr>
<th>Medications given at home:</th>
<th>Medications given at school:</th>
<th>Important information we should know about your child...</th>
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<tr>
<th>What techniques of discipline do you find most effective?</th>
<th>If you could describe your child in one phrase, what would it be?</th>
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**Child’s Medical Insurance Coverage**

<table>
<thead>
<tr>
<th>Insurance Company/Medicaid Provider</th>
<th>Member Policy Number</th>
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**Family Income Information**

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<th>Family Income Information</th>
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<tbody>
<tr>
<td>☐ $0-9,999</td>
</tr>
<tr>
<td>☐ $10,000-14,999</td>
</tr>
<tr>
<td>☐ $15,000-24,999</td>
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<tr>
<td>☐ $25,000-34,999</td>
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**NEW YORK STATE**  
**OFFICE OF CHILDREN AND FAMILY SERVICES**

**DAY CARE REGISTRATION** *(Required for Emergency Binder)*

### Child’s Full Name:

<table>
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<tr>
<th>Does your child have any allergies?</th>
<th>☐ Yes</th>
<th>☐ No</th>
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</table>

If Yes, what is your child allergic to:

Children who have special health care needs are those who have chronic physical, developmental behavioral or emotional conditions expected to last 12 months or more and who also require health and related services of a type beyond that required by children generally. If your child does have special health care needs please discuss these with your child-care provider.

### Child’s Source of Medical Care/Primary Care Physician’s Name:

<table>
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<tr>
<th>Number:</th>
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| Child’s Source of Central Care/Dentist’s Name: |
| Number: |

| Name of Medical Care Facility/Hospital: |
| Number: |

Would you like information on Child Health Plus? ☐ Yes ☐ No

### RELATIONSHIP | CONTACT NAME | TELEPHONE NUMBER DURING CHILD CARE | OTHER TELEPHONE NUMBER
---|---|---|---

### CHILD’S FULL NAME: ☐ Male ☐ Female

| CHILD’S HOME ADDRESS: |
| DATE OF BIRTH: |
| HOME TELEPHONE NUMBER: |

| DATE OF ACCEPTANCE: |
| DATE OF DISCHARGE: |

| NAME OF PERSON APPLYING FOR CHILD: ☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative ☐ Other |
| HOME TELEPHONE NUMBER: |

| ADDRESS OF PERSON LISTED ABOVE: (IF DIFFERENT FROM CHILD’S): |
| DAYTIME TELEPHONE NUMBER: |

### AGREEMENTS

I consent to the enrollment of the child listed above in this facility and have been advised of the policies regarding administration of medications, fees, transportation and the services provided by the facility, and the Office of Children and Family Services regulations under which it operates.

I give consent for my child to take part in neighborhood trips (i.e. library, park and playground) away from the facility under proper supervision. ☐ Yes ☐ No

In case of accident or injury, I authorize any and all emergency medical, dental, and/or surgical care and hospitalization advised by the physicians, surgeon or hospital (listed above) necessary for the proper health and well-being of my child. ☐ Yes ☐ No

I have provided information on my child’s special needs (Allergies, Diet, Disabilities, and/or Medical Information) to the provider, as may be necessary to assist the facility in properly caring for my child in case of an emergency. ☐ Yes ☐ No

I agree to review and update this information whenever a change occurs and at least once every six months. ☐ Yes ☐ No

**SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE**

**DATE**