Community Action Council of Portage County, Inc
Youth Center

CAC YOUTH CENTER

2017 MEMBER REGISTRATION

FOR STAFF USE ONLY

DATE RECEIVED ______________________ [ ] NEW MEMBER [ ] RENEWAL STAFF ______________________

MEMBER NAME(last)______________________________________ (first)__________________________________(m.i.) ________

STREET ADDRESS____**APT #**__________

CITY/STATE____ **ZIP** ______________**PHONE#**____________________

GENDER: [ ] MALE [ ] FEMALE **AGE** _______ **DATE OF BIRTH** ______________________

SCHOOL ___________________________________ **GRADE** ______________ **COUNSELOR** ______________________

DOES MEMBER HAVE AN IEP? __________________________ DATE, IF KNOWN?______________________

ACADEMIC CONCERNS____

ACADEMIC STRENGTHS____

CLUBS/ORGANIZATIONS, EXTRA-CURRICULAR ACTIVITIES, SPORTS

____

ETHNICITY: [ ] AFRICAN-AMERICAN [ ] ASIAN [ ] CAUCASIAN [ ] HISPANIC [ ] MULTI-RACIAL ……. U.S. CITIZEN [ ] YES [ ] NO

FAMILY INFORMATION

MEMBER RESIDES WITH: [ ] Both Parents [ ] Mother [ ] Father [ ] Grandparent(s) [ ] Foster/Kinship [ ] Other

PARENTS ARE: [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Mother's/Guardian's name _________________________________Father's/Guardian's name _________________________

In household: (live with member) _____ Brother(s) _____ Sister(s) _____ Others________

Please describe any medical problems, conditions, or FOOD ALLERGIES:

____

Medications & Side Effects:

____

SIGNATURE____**DATE**______________

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PICK-UP INFORMATION

ONLY THE INDIVIDUALS LISTED WILL BE PERMITTED TO PICK UP YOUR CHILD
THE INDIVIDUAL MUST BE AN ADULT (18 OR OLDER) & ID IS REQUIRED

1) **NAME**________________________________**RELATIONSHIP**_______________________

PHONE # _____________________________ **CELL #** _______________________________

2) **NAME**________________________________**RELATIONSHIP**_______________________

PHONE # _____________________________ **CELL #** _______________________________

3) **NAME**________________________________**RELATIONSHIP**_______________________

PHONE # _____________________________ **CELL #** _______________________________

4) **NAME**________________________________**RELATIONSHIP**_______________________

PHONE # _____________________________ **CELL #** _______________________________

PERMISSION TO WALK: My child has permission to walk home from CAC YOUTH CENTER daily.
___ Yes
___ No

USE OF INTERNET: My child has permission to use/access the internet at CAC YOUTH CENTER.
___ Yes
___ No

Signature ___________________________________**Date** ______________________________

****

T-shirt Size: (*for Summer Camp only*)

___Youth Small ___Adult Small

___Youth Medium ___Adult Medium

___Youth Large ___Adult Large

___Youth X-Large ___Adult X-Large

___Adult XX-Large

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EMERGENCY MEDICAL AUTHORIZATION

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under CAC Youth Center authority, when parents or guardians cannot be reached.

Student's Name: ______________________________________ Birthdate:____________________ Grade:____________

Home Address:_____________________________________ Teacher/Homeroom:______________________________

City/State/Zip:____ Date of Last Tetanus:___________________________

Student resides with:______Mother ______Father ______Stepparent ______Guardian ______ Other __________

List only the names (first and last) of those who have authority to make decisions in an **EMERGENCY** situation involving this student.:

1. Mother: ____________________________________ Home#: ________________ Work#: ________________

2. Father: ____________________________________ Home#: ________________ Work#: ________________

3. Guardian: __________________________________ Home#: ________________ Work#: ________________

4. Stepparent: ________________________________ Home#: ________________ Work#: ________________

In case of **ILLNESS**, list persons to notify in order of preference:

1. Name/Relationship ___________________________ Home#: ________________ Work#: ________________

2. Name/Relationship ___________________________ Home#: ________________ Work#: ________________

3. Name/Relationship ___________________________ Home#: ________________ Work#: ________________

COMPLETE ONLY ONE OF THE FOLLOWING:

I. **Consent for Treatment**
In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the preferred doctor indicated, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

I hereby give consent for the following medical care providers and local hospital to be called:

Preferred Physician ______________________________________ Office Phone __________________________________

Preferred Dentist ____ Office Phone __________________________________

Medical Specialist _______________________________________ Office Phone __________________________________

Preferred Hospital _______________________________________ Office Phone __________________________________

Parent/Guardian Signature ___________________________________ Date __________________________________

Medical History: Facts concerning the child's medical history including allergies, medications being taken, and any physical impairment of which a physician and/or school personnel should be alerted:

____

____

II. **Refusal of Treatment:**

I DO NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the CAC of Portage County authorities to take the following action:

____

Parent/Guardian Signature _______________________________________ Date ______________________

Address: ____
Street City State Zip Code

Medical History: Facts concerning the child's medical history including allergies, medications being taken, and any physical impairment of which a physician and/or school personnel should be alerted:

____

____

____

____

Community Action Council of Portage County, Inc
Youth Center

Field Trip & Special Event Consent Form

____

Name of Youth Emergency Contact Name & Phone #

In consideration of my child (or ward) being permitted to participate in CAC Youth Center's activities/events, I voluntarily agree to the following:

1. I understand that only youth with current CAC Youth Center memberships and up-to-date and accurate membership information (i.e., telephone numbers, addresses, emergency contact information, etc.) are permitted to participate in field trips and special events. By signing below, I acknowledge that my child (or ward) is a current member of the Youth Center and that all membership information provided to the Youth Center is correct.
2. I understand the anticipated times of departure and return for field trips/special events and will ensure that my child (or ward) is at the departure location at least fifteen (15) minutes prior to the time indicated and that arrangements have been made for someone to pick up my child (or ward) at the anticipated time of return. I understand and agree that my child (or ward) must be picked up upon return from the field trip/special event, unless return will be during Youth Center hours.
3. I have explained to my child (or ward) the expectations for conduct outlined in the Parent/Member Rules & Expectations Sheet and will make myself available during the field trip/special event, promptly upon being requested to do so, if my child's (or ward's) behavior warrants my presence.
4. I understand that all activity has a degree of risk associated with it and agree to hold harmless and indemnify the Community Action Council of Portage County and its employees and volunteers from and against any claims, demands, liability, costs of suit, damages, loss and/or judgments in connection with the Youth Center activities, field trips/special events which may be asserted by me, my child (or ward) or anyone else on our behalf and assume the responsibility for any losses, costs, and/or damages that may arise from any injury to my child (ward).
5. **<u>I understand and agree that the Youth Center cannot and will not administer prescription or over the counter medications of any kind to my child (or ward), with the exception of Epi-pen or Inhaler or previously discussed medication. If my child (or ward) requires medical attention and I cannot be reached in a timely fashion, I give permission to the staff/designees of the CAC Youth Center to transport, hospitalize, and secure any medical treatments they deem necessary including, but not limited to, X-rays, routine test, injections, and surgery. I accept full financial responsibility for such treatments or medical attention.</u>**

The undersigned represents that he/she is the parent and/or legal guardian of the minor named above, and represents that he/she has the legal authority to execute this consent and release. If the child/applicant is signing for him or herself, the undersigned warrants that he/she has reached the age of legal majority according to the State of Ohio.

____

Signature of Parent/Guardian Date Phone #

PHOTO RELEASE

Date ___________________________

I, _______________________________________ grant permission to the Community Action Council of Portage County, Inc. /Youth Center, and its authorized agents, to photograph and use photos of my child, _________________________ (past, present or future), schools, counselors, school publications or school related agencies and other entities that it deems necessary for program compliance related to my child's participation in the agency's Youth Programs and Learning Centers. I understand that photos will be used for purposes of record keeping and after-school and school related publication and will not be shared with individuals or organizations not specified herein.

____
Participant Signature and date

____
Parent or Guardian Signature

____
Witness and Date (CAC Staff)

<u>Rules/Expectations</u>

1. Respect everyone.
2. Pick up after yourself and return items to their proper place.
3. Walk inside the building.
4. We will use appropriate language at all times.
5. Yelling and shouting will not be tolerated.
6. Always ask permission to enter all areas.
7. Food and Drink in assigned areas only.
8. Fighting or bullying will not be tolerated.
9. Stealing and destroying property will not be tolerated.
10. Computer access is given by permission only. If inappropriate material is being accessed, permission will be revoked. Downloading material is not permitted.
11. You must be signed in and out daily.
12. You must be dressed appropriately or you will be asked to change clothes or go home.
13. Staff Offices and Kitchen are off limits (STAFF ONLY in these areas)
14. Make good choices and Have Fun!

You must have permission to bring outside electronics, toys, games, etc. into the building and those items are *your* responsibility. Items brought without permission will be held until the end of the day. CAC is not responsible for personal items brought to the center that get lost or stolen.

Once you sign-out, you are not permitted to return for the day without a parent letter.

If these rules are not followed, disciplinary action will be taken, beginning with time-out to suspension from CAC youth programs.

<u>*Hours of Operation*</u>: Academic School Year 3:00pm-6:00pm
Winter/Spring Break 9:00am-3:00pm
Summer Camp 8:15am-4:00pm

During the School Year, children must be picked up by 6:00pm. During Summer Camp, children must be picked up by 4:00pm. There is a late fee for late pick-ups at the rate of $1/minute, payable by week's end to continue to participate in Youth Center services.

By signing this, I hereby understand and shall abide by the rules herein and accept responsibility for my actions.

____

CAC Youth Member Signature   Parent Signature/ Date

Community Action Council of Portage County, Inc
Youth Center

Survey I.

1. How did you hear about us?

   ____

2. Has your child attended CAC Youth Center in the past? YES NO
3. If so, did you and your child enjoy CAC Youth Center? YES NO
4. Would you recommend CAC Youth Center to friends? YES NO
5. Overall, you chose CAC Youth Center Camp for the following reasons: *(check all that apply)*
   a. ____Hours open
   b. ____Play/Activity area
   c. ____Activities planned
   d. ____Learning Opportunities
   e. ____Availability of Meals/Snacks
   f. ____Trips
   g. ____Staff
   h. ____Safety
   i. ____Cost
   j. ____Convenience
6. Are you available to participate in CAC activities, trips, etc.? YES NO
7. Have all of your questions or concerns been addressed? YES NO
8. What changes could we make to improve the Youth Center?

   ____

9. What are you/your child most looking forward to at CAC Youth Center?

   ____

10. Additional comments or feedback:

    ____

    ____

Thank You.

COMMUNITY ACTION COUNCIL OF PORTAGE COUNTY, INC.
INTAKE FORM

SS# ____________________ LAST NAME ____________________ FIRST NAME ____________________

DOB ____________________ ADDRESS ____

CITY ____________________ ZIP CODE ______________ TELEPHONE ( ) ____________________

GENDER: ☐ FEMALE ☐ MALE

DISABLED: ☐ YES ☐ NO

ETHNICITY: ☐ BLACK/AFRICAN AMERICAN ☐ HISPANIC ☐ ASIAN ☐ WHITE/CAUCASIAN ☐ NATIVE AMER. ☐ OTHER

EDUCATION: ☐ 0-8 ☐ 12+ ☐ 9-12 (NON-GRAD) ☐ UNKNOWN ☐ HS GRAD/GED ☐ COLLEGE GRAD.

FOOD STAMPS: ☐ YES ☐ NO

HEALTH INSURANCE: ☐ MEDICAID ☐ SELF-INS ☐ MEDICARE ☐ NONE ☐ PRIVATE ☐ UNKNOWN

FARMER: ☐ FARMER ☐ MIGRANT ☐ SEASON

VETERAN: ☐ YES ☐ NO

IN HSHLD

FAMILY TYPE: ☐ SINGLE PAR/FEMALE ☐ SINGLE ☐ SINGLE PAR/MALE ☐ COUPLE ☐ TWO PARENT ☐ OTHER

HOUSING: ☐ OWN ☐ RENT ☐ HOMELESS

CLIENT INCOME: ☐ WEEKLY ☐ ANNUAL ☐ BI-WEEKLY ☐ 13-WEEKS ☐ MONTHLY ☐ AMOUNT: ______

SOURCES OF INCOME: ☐ EMPLOYMENT ☐ SOCIAL SECURITY ☐ DA ☐ PENSION ☐ OTHER ☐ UNEMPLOYMENT ☐ AFDC/TANF ☐ SSI/SSD ☐ DISABILITY

U.S. CITIZEN: ☐ YES ☐ NO

HOUSEHOLD MEMBERS					
SS#					
LAST NAME					
FIRST NAME					
DATE OF BIRTH					
GENDER					
DISABLED					
ETHNICITY					
EDUCATION					
HEALTH INS.					
VETERAN					
INCOME PERIOD					
AMOUNT					
SOURCE					
U.S. CITIZEN	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

I certify that this statement is true and correct to the best of my knowledge, and authorize the release of any or all information necessary for verification purposes.

____ SIGNATURE OF CLIENT ____________ DATE

COMMENTS ____

____

____

____ INTAKE INITIALS ____________