WATERVLIET CIVIC CENTER BEFORE & AFTER SCHOOL PROGRAM
2024-2025 SCHOOL YEAR APPLICATION

CHILD' NAME:	CELL:
ADDRESS:	CITY:
D.O.B. GENDER:	GRADE (in Sept. 2024):

PARENT/GUARDIAN'S NAME:	CELL PHONE:
ADDRESS:	CITY:
STATE: ZIP:	HOME PHONE:
EMPLOYER:	WORK PHONE:
EMAIL ADDRESS:	

PARENT/GUARDIAN'S NAME:	CELL PHONE:
ADDRESS:	CITY:
STATE: ZIP:	HOME PHONE:
EMPLOYER:	WORK PHONE:
EMAIL ADDRESS:	

IN CASE OF AN EMERGENCY, LIST PEOPLE TO BE CONTACTED IF NEITHER PARENT CAN BE REACHED. *MUST BE IN ADDITION TO PARENTS OR GUARDIAN AND SHOULD NOT BE AT THE SAME ADDRESS. YOUR CHILD WILL ONLY BE RELEASED TO THE INDIVIDUALS ON THIS FORM. ALL OF THE INDIVIDUALS LISTED MUST BE AT LEAST 16 YEARS OF AGE AND HAVE PHOTO IDENTIFICATION.

NAME:	CELL PHONE:
ADDRESS:	CITY:
STATE:	ZIP:
WORK PHONE:	EMPLOYER:
RELATIONSHIP TO CHILD:	HOME PHONE:
NAME:	CELL PHONE:
ADDRESS:	CITY:
STATE:	ZIP:
WORK PHONE:	EMPLOYER:
RELATIONSHIP TO CHILD:	HOME PHONE:
NAME:	CELL PHONE:
ADDRESS:	CITY:
STATE:	ZIP:
WORK PHONE:	EMPLOYER:
RELATIONSHIP TO CHILD:	HOME PHONE:

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PLEASE LIST NAME OF FAMILY DOCTOR, HOSPITAL OF CHOICE IN CASE OF EMERGENCY, ALLERGIES, DISABILITIES, MEDICAL CONDITIONS & HEALTH INSURANCE INFORMATION

FAMILY DOCTOR:		
ADDRESS:	TELEPHONE:	
CITY:	STATE:	ZIP:
ALLERGIES:		
MEDICATIONS CURRENTLY TAKEN:		
IF YOUR CHILD HAS ANY MEDICAL CONCERNS, PLEASE COMPLETE THE ATTACHED INDIVIDUAL HEALTH CARE PLAN FORM, OCFS FORM #7006		
HOSPITAL OF CHOICE:		
HEALTH INSURANCE COMPANY:		POLICY #

IN CASE OF AN EMERGENCY, I UNDERSTAND THAT EVERY EFFORT WILL BE MADE TO CONTACT THE PARENTS/GUARDIAN. IN THE EVENT THE PARENT/GUARDIAN CANNOT BE REACHED, THE CHILD WILL BE TRANSPORTED TO THE HOSPITAL PRE-SELECTED BY THE PARENT OR GUARDIAN.

I HAVE RECEIVED A COPY OF THE WATERVLIET CIVIC CENTER SCHOOL-AGE CHILD CARE PARENT HANDBOOK AND BY SIGNING THIS APPLICATION I ACKNOWLEDGE THAT I UNDERSTAND AND AGREE TO ABIDE BY THE POLICIES AND PROCEDURES CONTAINED THEREIN.

GENERAL WAIVER OF LIABILITY: MY CHILD PLANS TO PARTICIPATE IN THE WATERVLIET CIVIC CENTER 2024-2025 BEFORE & AFTER SCHOOL PROGRAM, BY SIGNING THIS RELEASE AND APPLICATION FORM, I UNDERSTAND THAT THE WATERVLIET CIVIC CENTER WILL NOT BE RESPONSIBLE FOR INJURY TO PERSON OR PROPERTY.

PARENT/GUARDIAN NAME:_____
(please print)

PARENT SIGNATURE_____DATE_____

PLEASE CHECK WHICH PROGRAM YOU WISH TO ENROLL YOUR CHILD IN

BEFORE SCHOOL____ AFTER SCHOOL____ BOTH____

Watervliet Civic Center
2024-2025 Before & After School Program
Program Closure Form

If the Watervliet City School District closes at regular dismissal time, but they cancel their after-school activities the Watervliet Civic Center will not operate our After School Program. The Watervliet Civic Center will implement the following procedures to ensure children are safely released. Please note that regular dismissal time will be approximately 2:00 PM for Pre-K children and 3:15 PM for children in Kindergarten to 5th Grade and approximately 2:20 PM for 6th Grade.

- The Watervliet Civic Center will utilize our automated message system to send a detailed automated recording about the program closure to your phone. Since this is the way we will notify you of any program closures, it is important that every family is signed up for the automated system. Please make sure you update us immediately any time telephone numbers and other contact information changes.
- Program closure will also be posted on the Watervliet City School District's website; www.watervlietcityschools.org
- The Watervliet City School District has a web-based messaging system called Parent Square. This system notifies parents via phone, email and text message of important district news and information, including school closings, delays and/or early dismissals. Parent Square automatically integrates contact information including phone numbers and email addresses from the district's management system, e-Schools Data, for parents/guardians of every student enrolled in Watervliet schools.
- It will be the responsibility of the parent to make sure that their child arrives home safely.
- Parents have the option of having their child picked-up by individuals listed on the pick-up list or take the bus home.
- **Please check one of the options listed below**.

_____ My child will be picked-up by one of the individuals listed below.

Name	Telephone Number

_____My child is allowed to take the bus home. Please include bus #:_____
Your child must be registered in the transportation department if you choose this option.

I have read the program closure form and I am aware of the procedures that must be followed in the event that there is no Watervliet Civic Center After School Program.

Child's Name:_____ Grade_____

Parent/Guardian Name:_____
(please print)

Parent/Guardian Signature:_____ Date:_____

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
INDIVIDUAL ALLERGY AND ANAPHYLAXIS EMERGENCY PLAN

Instructions:

- This form is to be completed for any child with a known allergy.
- The child care program must work with the parent(s)/guardian(s) and the child's health care provider to develop written instructions outlining what the child is allergic to and the prevention strategies and steps that must be taken if the child is exposed to a known allergen or is showing symptoms of exposure.
- This plan must be reviewed upon admission, annually thereafter, and anytime there are staff or volunteer changes, and/or anytime information regarding the child's allergy or treatment changes. This document must be attached to the child's Individual Health Care Plan.
- Add additional sheets if additional documentation or instruction is necessary.

Child's Name: Date of Plan: / /
Date of Birth: / / Current Weight: lbs.
Asthma: ☐ Yes (higher risk for reaction) ☐ No

My child is reactive to the following allergens:

Allergen:	**Type of Exposure:** (*i.e., air/skin contact/ingestion, etc.*):	**Symptoms Include but are not limited to:** (*check all that apply*)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)

If my child was LIKELY exposed to an allergen, for ANY symptoms:
☐ give epinephrine immediately

If my child was DEFINITELY exposed to an allergen, even if no symptoms are present:
☐ give epinephrine immediately

Date of Plan: / /

THE FOLLOWING STEPS WILL BE TAKEN IF THE CHILD EXHIBITS SYMPTOMS including, but not limited to:

- **Inject epinephrine immediately and note the time when the first dose is given.**
- **Call 911/local rescue squad** (Advise 911 the child is in anaphylaxis and may need epinephrine when emergency responders arrive).
- Lay the person flat, raise legs, and keep warm. If breathing is difficult or the child is vomiting, allow them to sit up or lie on their side.
- If symptoms do not improve, or symptoms return, an additional dose of epinephrine can be given in consultation with 911/emergency medical technicians.
- Alert the child's parents/guardians and emergency contacts.
- After the needs of the child and all others in care have been met, immediately notify the office.

MEDICATION/DOSES

- Epinephrine brand or generic:
- Epinephrine dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

ADMINISTRATION AND SAFETY INFORMATION FOR EPINEPHRINE AUTO-INJECTORS

When administering an epinephrine auto-injector follow these guidelines:

- Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than the mid-outer thigh. If a staff member is accidentally injected, they should seek medical attention at the nearest emergency room.
- If administering an auto-injector to a young child, hold their leg firmly in place before and during injection to prevent injuries.
- Epinephrine can be injected through clothing if needed.
- Call 911 immediately after injection.

STORAGE OF EPINEPHRINE AUTO-INJECTORS

- All medication will be kept in its original labeled container.
- Medication must be kept in a clean area that is inaccessible to children.
- All staff must have an awareness of where the child's medication is stored.
- Note any medications, such as epinephrine auto-injectors, that may be stored in a different area.
- Explain here where medication will be stored:

MAT/EMAT CERTIFIED PROGRAMS ONLY

Only staff listed in the program's Health Care Plan as medication administrant(s) can administer the following medications. Staff must be at least 18 years old and have first aid and CPR certificates that cover all ages of children in care.

- Antihistamine brand or generic:
- Antihistamine dose:
- Other (e.g., inhaler-bronchodilator if wheezing):

***Note: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

STORAGE OF INHALERS, ANTIHISTAMINES, BRONCHODILATOR

All medication will be kept in its original labeled container. Medication must be kept in a clean area that is inaccessible to children. All staff must have an awareness of where the child's medication is stored. Explain where medication will be stored. Note any medications, such as asthma inhalers, that may be stored in a different area.

Explain here:

STRATEGIES TO REDUCE THE RISK OF EXPOSURE TO ALLERGIC TRIGGERS

The following strategies will be taken by the child care program to minimize the risk of exposure to any allergens while the above-named child is in care (add additional sheets if needed):

Document plan here:

EMERGENCY CONTACTS – CALL 911	
Ambulance: ( ) -	
Child's Health Care Provider:	Phone #: ( ) -
Parent/Guardian:	Phone #: ( ) -
CHILD'S EMERGENCY CONTACTS	
Name/Relationship:	Phone#: ( ) -
Name/Relationship:	Phone#: ( ) -
Name/Relationship:	Phone#: ( ) -

Parent/Guardian Authorization Signature:	Date: / /
Physician/HCP Authorization Signature:	Date: / /
Program Authorization Signature:	Date: / /

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

You may use this form or an approved equivalent to document an individual health care plan developed for a child with special health care needs.

A child with a special health care need means a child who has a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and who requires health and related services of a type or amount beyond that required by children generally.

Working in collaboration with the child's parent and child's health care provider, the program has developed the following health care plan to meet the individual needs of:

CHILD NAME:	CHILD DATE OF BIRTH: / /
NAME OF THE CHILD'S HEALTH CARE PROVIDER:	☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner

Describe the special health care needs of this child and the plan of care as identified by the parent and the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment.

Identify the caregiver(s) who will provide care to this child with special health care needs:

Caregiver's Name	Credentials or Professional License Information (if applicable)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

Describe any additional training, procedures or competencies the caregiver identified will need to carry out the health care plan for the child with special health care needs as identified by the child's parent and/or the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment. In addition, describe how this additional training and competency will be achieved including who will provide this training.

This plan was developed in close collaboration with the child's parent and the child's health care provider. The caregivers identified to provide all treatments and administer medication to the child listed in the specialized individual health care plan are familiar with the child care regulations and have received any additional training needed and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

PROGRAM NAME:	FACILITY ID NUMBER:	PROGRAM TELEPHONE NUMBER: ( )
CHILD CARE PROVIDER'S NAME (PLEASE PRINT):		DATE: / /
CHILD CARE PROVIDER'S SIGNATURE: X		

I agree this Individual Health Care Plan meets the needs of my child. Yes ☐ No ☐

I give consent to share information about my child's allergy with all program caregivers in a non-discreet way. I support the strategies the program implements to keep my child from being exposed to known allergen(s). I acknowledge these strategies may include visual reminders that may result in the disclosure of my child's confidential allergy information to non-child care staff. Yes ☐ No ☐

Signature of Parent:

	DATE:
X	/ /

SPECIAL NEEDS PLAN FOR A CHILD

WITH ENVIRONMENTAL OR SEASONAL ALLERGIES

Child's Name: _____ Child's DOB: _____

Does this child have asthma? **Yes** **No** Child's Weight: _____

This plan is designed to be completed for a child with seasonal/environmental allergies that are not life threatening and do not require emergency medication. *By completing this form, staff will have a better understanding of the child's allergy, including triggers, symptoms and what treatment may be required. Any required medication will be stored per the programs approved Health Care Plan.*

- The abovenamed child has a diagnosis of (please circle):
  Seasonal Allergies **Environmental Allergies** Other: _____

- Is the child on **medication** for the allergy? **Yes** **No**
  - If you answered **Yes** above, is the medication needed in care? **Yes** **No**
    *See written Medication Consent form for medication(s) needed in care.
  - Is this medication an emergency medication (Epinephrine, Diphenhydramine, Inhaler, Nebulizer)? **Yes** **No**
    *If you answered **Yes** above, you must complete the **OCFS-LDSS-6029**

- **Known triggers** for child's allergy (circle all that apply):

Animals/Pet Dander Chemical Odors Flowers Grass Dust Mold
Perfumes/Scents Season Changes (Specify: _____) Pollen
Other: _____

- Typical signs & symptoms the child experiences with the allergy (circle all that apply):

Runny Nose Sneezing Coughing Congestion Itchy/watery eyes Puffy eyes
Itchy Throat Post-Nasal Drip Other: _____

Do you consider these signs/symptoms to be mild or severe? _____

How frequent are these symptoms? **Daily** **Intermittent** **Infrequent**

- Strategies to reduce the risk of exposure to the child's known triggers include:

_____
_____
_____
_____

- **Are there any accommodations needed in care for the child or special instructions for staff (explain below or write N/A):**_____

_____

_____

_____

_____

- **The program staff who will care for the child with special health care needs are:**

Staff:	**Credentials:**
_____	_____
_____	_____
_____	_____
_____	_____

- **Does staff need any additional training to care for the child? Yes No**
  - **If Yes, specify:** _____
- **Reasons to contact the parent:** _____
- **Reasons to call 911: Difficulty breathing or signs/symptoms of anaphylaxis.**

This plan was developed in close collaboration with the child's parent/guardian and the child's health care provider. The program understands their responsibility to follow this plan and assure that the caregivers listed above understand the plan, as well as maintain the appropriate credentials needed to care for the child.

Child's Health Care Provider: _____ **Phone #:** _____
Health Care Provider Signature: _____

Provider/Program Name: _____
License/Registration #: _____ Program Telephone #: _____
Child Care Provider's Name (please print): _____
Child Care Provider's Signature: _____ Date: _____

Name of Parent/Guardian: _____ Phone #: _____
Signature of Parent/Guardian: _____ Date: _____