

**AFTER SCHOOL PROGRAM**

**at RLASHS**

**2022-2023**

**APPLICATION / EMERGENCY INFORMATION FORM**

**Student’s Name**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street City State Zip

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School Building 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 2:45 PM - 6:00 PM.?

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street City State Zip

**Student’s Physician**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street City State Zip

Hospital \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please complete this form and return it to: The Arc of York County**

 **497 Hill Street**

 **York, PA 17403**

Revised 7/16/19 **This information will be kept strictly confidential. Thank you.**

# 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

**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 County’s 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. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**AGREEMENT**

This agreement is between The Arc of York County 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 2:45 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 Red Lion Area School District's 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 County. These activities may occur at either the Red Lion Area Senior High School, 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 County, Inc., (or its affiliates) or its staff, we hereby release The Arc of York County; Red Lion Area School District, 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 County, and Red Lion Area School District for any loss or damage to my child’s property, whether at the school, 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 County 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**

 \*\*needed for students who *do not attend* RLASHS

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ will be attending The Arc of York County’s

(Name of Student)

After School Options Program beginning on the following date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (First Day of Transportation)

Red Lion Area School District, or its sub-contractors, has my permission to transport my child to Red Lion Area Senior High School at 200 Horace Mann Ave., Red Lion, PA 17356, 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.

**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 COUNTY** **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 one 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

\_\_\_\_\_ $11,251---12,850

\_\_\_\_\_ $12,851---14,450

\_\_\_\_\_ $14,451---16,100

\_\_\_\_\_ $16,101---17,350

\_\_\_\_\_ $17,351---18,650

\_\_\_\_\_ $18,651---18,750

\_\_\_\_\_ $18,751---19,950

\_\_\_\_\_ $19,951---21,250

\_\_\_\_\_ $21,251---21,450

\_\_\_\_\_ $21,451---24,100

\_\_\_\_\_ $24,101---26,800

\_\_\_\_\_ $26,801---28,950

\_\_\_\_\_ $28,951---30,000

\_\_\_\_\_ $30,001---31,100

\_\_\_\_\_ $31,101---33,250

\_\_\_\_\_ $33,251---34,300

\_\_\_\_\_ $34,301---35,400

\_\_\_\_\_ $35,401---38,600

\_\_\_\_\_ $38,601---42,900

\_\_\_\_\_ $42,901---46,300

\_\_\_\_\_ $46,301---49,750

\_\_\_\_\_ $49,751---53,150

\_\_\_\_\_ $53,151---56,600

\_\_\_\_\_ 56,601 & over

\_\_\_\_\_ Unknown

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The Arc of York County**

Medical Needs Survey

Please feel free to offer any additional comments to the questions in this survey.

Participation in this survey is optional. It can be completed anonymously if preferred. By completing this form, you will be assisting The Arc of

York County staff to advocate for people with disabilities with regard to medical services including both general practice and specialties.

1. When seeking medical treatment/services is it important to you that the provider has

experience treating people with intellectual/developmental disabilities.

2. Have you had difficulty in the past finding doctors who are comfortable serving individuals

with intellectual and other disabilities.

3. If The Arc identified medical service providers who are experienced with and recommended

for people with intellectual and other disabilities, would that information be useful to you?

4. Are you currently satisfied that your medical provider has a thorough understanding of

your family member’s disability and how to serve them?

5. Would it be important for you to have cooperating providers in one location?

Signature (optional)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name (optional)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_