Administrative Office
1000 N. Vandeventer, 2nd floor
St. Louis, MO 63113
Fax # 314-361-6873
Email: ghampton@upstl.org

UNLEASHING POTENTIAL

EARLY CHILDHOOD
AFTER SCHOOL
YOUTH DEVELOPMENT
ENRICHMENT CAMPS

*Formerly Neighborhood Houses*

Staff Only
Date Received: _____

Reviewed by: _____

Parent Contacted: _____

## Enrollment Check List

**Child's Name: _____*Current Grade Level_____**

**Date of Birth: _____ Age: _____**

***Please complete all forms. Please note that any incomplete or unclear information will delay the registration process. Submission of forms does not guarantee placement. An Unleashing Potential representative will contact you within 48 hours of receipt of the application. Application can be submitted to the administrative office. See address above.***

| | |
|---|---|
| **Registration Form**<br>**Note: Life threatening allergies and asthma require a medical action plan and medication from your doctor to be on hand with Unleashing Potential. Students may not start program without these items.** | ☐ |
| **Agreements (Initials & signature required)** | ☐ |
| **Club Activity Release (Signature Required)** | ☐ |
| **Parents Rights (Signature required)** | ☐ |
| **Intake Assessment (Signature required)** | ☐ |
| **Immunization Records** | ☐ |

***Please indicate your location choice.***

☐ **Griffith (AM & PM)** ☐ **Berkeley (AM &PM)**

***Attendance Pattern – Please check the days and times your child will attend program weekly.***

| | | | | | |
|---|---|---|---|---|---|
| **AM Only** | ☐ **Monday** | ☐ **Tuesday** | ☐ **Wednesday** | ☐ **Thursday** | ☐ **Friday** |
| **PM Only** | ☐ **Monday** | ☐ **Tuesday** | ☐ **Wednesday** | ☐ **Thursday** | ☐ **Friday** |
| **AM & PM** | ☐ **Monday** | ☐ **Tuesday** | ☐ **Wednesday** | ☐ **Thursday** | ☐ **Friday** |

Proud member of United Way of Greater St. Louis

21st Century Community Learning Centers — Soaring Beyond Expectations

# Youth Intake Assessment Form

Date: _____

Youth Name:_____ Age:____

Parent/Guardian's Name: _____

School Child Attends: _____ Grade Level:_____

Teacher's Name: _____

| *Please complete the following checklist on your child so that the Unleashing Potential can get to know him/her better. When completing the checklist, please think about how your child is usually and select that response that best fits your child.* | | | |
|---|---|---|---|
| My child…. | Most of the time | Some of the time | Not usually |
| 1. Listens to and follows directions of those in charge | | | |
| If not usually, what types of reminders are helpful | | | |
| 2. Can make his/her own decisions:<br>-with peer input<br>-without peer input | | | |
| 3. Gets along with peers | | | |
| 4. Gets along with adults | | | |
| 5. Is able to take care of own physical needs | | | |
| If not, what does she/he need assistance with | | | |
| 6. Is able to independently choose and participate in activities | | | |
| If not, what supports does he or she need | | | |
| 7. Has skills to negotiate needs/wants when they differ from needs of the group | | | |
| 8. Requests help from adults when needed | | | |
| If not, how can we help meet his/her needs | | | |
| 9. Works/plays with a variety of children | | | |
| 10. Prefers small group | | | |
| 11. Prefers large group activity | | | |
| Please complete the following information on your child. | | | |
| What helps your child study/complete afterschool assignments? | | | |
| In new situations, my child tends to. . . | | | |

| | | |
|---|---|---|
| My child works and plays best when. . . | | |
| Some of my child's favorite things are….<br>1)<br><br>2)<br><br>3) | | |
| When your child gets frustrated or upset what does she or he find calming and soothing?<br>What helps to get him/her back on track? | | |
| Does your child receive services from other service agencies, such as Special School District or St. Louis Regional Center? | Yes | No |
| If yes, please provide us with a copy of the I.E.P. so we can ensure that to the extent possible we are providing supports needed to meet his/her special needs. | Yes | No |
| Copy attached? | Yes | No |
| What type of support, if any, does your child need during the school day? | Yes | No |
| Please describe support needed during school day: | | |
| Please explain any special needs your child may have: (allergies, dietary needs, physical concerns, self-help assistance in dressing, using the bathroom, and or self-advocating, communication concerns. | | |
| How does your child receive praise? | | |
| Any additional comments you would like us to know about your child? | | |
| Parent/Guardian has initialed the release of confidential information agreement. | Yes | No |
| Unleashing Potential and your child's school are linked together in a partnership to ensure support systems yield compounded positive results. Unleashing Potential's staff and school staff, including classroom teachers, will communicate regularly regarding a student's progress. | | |
| The Intake Assessment and the Child Service Plan was discussed with parent/guardian.<br>Site Supervisor signature:_____ Date:_____ | | |

**Registration Form – Please fill in all blanks. Write N/A in spaces that are not applicable.**

| Site/Provider Name: | School Year: | Grade Level: | Admission Date: | Discharge Date: |
|---|---|---|---|---|
| Unleashing Potential | 2019/20 | | | |

| Child's Name: (First, MI, Last) | Birth Date: | Gender: | | | Special Needs: | |
|---|---|---|---|---|---|---|
| | | ☐ Male | ☐ Female | ☐ Other _____ | ☐ Yes _____ | ☐ No |

| Street Address: | City: | State: | Zip: |
|---|---|---|---|
| | | | |

| Lunch Status: | | | DCN #: | IEP: | | Behavior Plan: | |
|---|---|---|---|---|---|---|---|
| ☐ Free | ☐ Reduced | ☐ Full Pay | | ☐ Yes. If yes, please provide a copy | ☐ No | ☐ Yes | ☐ No |

| Race/Ethnicity: (Check all that apply) | | | Comments on Child's Development: |
|---|---|---|---|
| ☐ Black/African American | ☐ White/Caucasian | ☐ Hispanic or Latino | |
| ☐ Asian | ☐ American Indian/Alaska Native | ☐ Native Hawaiian/Pacific | |
| ☐ Other: _____ | | | |

| Insurance Status: | | Medical Issues: | | Please list any allergies, medications, or health problems: |
|---|---|---|---|---|
| ☐ Employer Insurance | ☐ Medicare | ☐ Allergies | ☐ Hyperactivity | |
| ☐ Healthcare Exchange | ☐ Medicaid | ☐ Epilepsy | ☐ Attention Deficit Disorder | |
| ☐ Private Insurance | ☐ Uninsured | ☐ Diabetes | ☐ Eyeglasses/Contacts | |
| | | ☐ Asthma | ☐ Hearing Aid | ☐ My child is in good health, is able to participate in group care, has no special health or medical requirements. |
| | | ☐ Other: | | ☐ My child is able to participate in group care but has special medical requirements as listed above. |
| | | | | ***Parent Initial*** _____ |

***Before admission additional information or accommodations may be requested for children with disabilities and/or special needs who require additional adult support. Once the information is received our team will review to determine if the program can accommodate the needs of the child. Allow a week after documents are submitted for confirmation.***

## AUTHORIZATION FOR EMERGENCY CARE AND TRANSPORTATION

*I understand that I will be notified at once in case of an emergency with my child, and I will make arrangements for medical care of my child with the physician or hospital of my choice. If I cannot be reached to make necessary arrangements, or in a critical emergency requiring medical care, I authorize* ***Unleashing Potential*** *to contact the following.*

***Parent Signature:*** _____

***Contact the following:***

| Physician or clinic name: | Phone Number: |
|---|---|
| | |
| **Preferred hospital:** | **Phone number:** |
| | |

## EMERGENCY CONTACTS / DESIGNATED ESCORTS - Persons authorized to take your child from the program other than Parent/Guardian (Escorts should be reliable and able to pick up and/or make emergency decisions regarding your child in case of an emergency)

| Contact Name: | Home Phone: | E-Mail Address: |
|---|---|---|
| | | |
| **Relationship to Student:** | **Alt Phone:** | **Authorized to Pick-Up Student:** |
| | | ☐ Yes ☐ No |

| Street Address: | City: | State: | Zip: |
|---|---|---|---|
| | | | |

| Contact Name: | Home Phone: | E-Mail Address: |
|---|---|---|
| | | |
| **Relationship to Student:** | **Alt Phone:** | **Authorized to Pick-Up Student:** |

| | | | |
|---|---|---|---|
| | | | ☐ **Yes** ☐ **No** |
| **Street Address:** | **City:** | **State:** | **Zip:** |
| | | | |

## PARENT/GUARDIAN INFORMATION

**Parent/Guardian's Name:** (First, MI, Last)

| Street Address: | City: | State: | Zip: |
|---|---|---|---|
| | | | |

| Email Address: | Home Phone: | Cell Phone: | Work Phone: |
|---|---|---|---|
| | | | |

**Employment Status:**
- ☐ Full Time Employed
- ☐ Part Time Employed
- ☐ Not Employed or Student
- ☐ Full Time Student
- ☐ Part Time Student

**Military/Veteran Status:**
- ☐ Yes, Active Military
- ☐ Yes, Reserve Military
- ☐ Yes, Prior Service
- ☐ No, None

**Education Level:**
- ☐ Less Than High School
- ☐ High School/GED
- ☐ Trade/Tech School
- ☐ Some College
- ☐ 2 Year Degree
- ☐ 4 Year Degree
- ☐ Post Graduate

**Insurance Status:**
- ☐ Employer Insurance
- ☐ Healthcare Exchange
- ☐ Private Insurance
- ☐ Medicare
- ☐ Medicaid
- ☐ Uninsured

| Name of Employer or School: | Work/School Address: | City: | State: | Zip: | Work/School Schedule: |
|---|---|---|---|---|---|
| | | | | | |

## PARENT/GUARDIAN INFORMATION

**Parent/Guardian's Name:** (First, MI, Last)

| Street Address: | City: | State: | Zip: |
|---|---|---|---|
| | | | |

| Email Address: | Home Phone: | Cell Phone: | Work Phone: |
|---|---|---|---|
| | | | |

**Employment Status:**
- ☐ Full Time Employed
- ☐ Part Time Employed
- ☐ Not Employed or Student
- ☐ Full Time Student
- ☐ Part Time Student

**Military/Veteran Status:**
- ☐ Yes, Active Military
- ☐ Yes, Reserve Military
- ☐ Yes, Prior Service
- ☐ No, None

**Education Level:**
- ☐ Less Than High School
- ☐ High School/GED
- ☐ Trade/Tech School
- ☐ Some College
- ☐ 2 Year Degree
- ☐ 4 Year Degree
- ☐ Post Graduate

**Insurance Status:**
- ☐ Employer Insurance
- ☐ Healthcare Exchange
- ☐ Private Insurance
- ☐ Medicare
- ☐ Medicaid
- ☐ Uninsured

| Name of Employer or School: | Work/School Address: | City: | State: | Zip: | Work/School Schedule: |
|---|---|---|---|---|---|
| | | | | | |

## HOUSEHOLD INFORMATION

**Total Household Income:**
- ☐ $0 to $9,999
- ☐ $10,000 to $14,999
- ☐ $15,000 to $19,999
- ☐ $20,000 to $29,999
- ☐ $30,000 to $49,000
- ☐ $50,000 to $99,000
- ☐ $100,000 or Greater

**Living Arrangements:**
- ☐ Both parents
- ☐ Mother only
- ☐ Father Only
- ☐ Both Grandparents
- ☐ One grandparent
- ☐ Only Guardian
- ☐ Other:

**Assistance Programs/Sources of Income:**
- ☐ Child Support
- ☐ Food Stamps
- ☐ Medicaid
- ☐ Veterans Compensation
- ☐ Daycare Voucher
- ☐ Other:
- ☐ TANF
- ☐ Unemployment
- ☐ SSI
- ☐ SSDI

| Total Household Size: | Total in Household under 18yi: |
|---|---|
| | |

**Single Head of House Hold?** ☐ Yes ☐ No

***Note: Demographic information provided is confidential and used solely for reporting /funding purposes only.***

## AGREEMENTS

| | Parent/Guardian Initials |
|---|---|
| At the time of orientation, I will receive a copy of Unleashing Potential's policies pertaining to the admission, care and discharge of children. I will abide by all policies and procedures of the program as documented in the Family Handbook. | |
| I understand that Unleashing Potential is a licensed facility and at the time of orientation, I will be informed that a copy of the Licensing Rules for Group Child Care Homes and Centers is available at this facility for my review. | |
| Unleashing Potential and I will agree upon a plan for continuing communication regarding my child's development, behavior and individual needs. | |
| I understand and agree that when my child is ill, he/she may not be accepted for care or remain in care and that I or a designated escort will be contacted and must come to pick up my child from the program. | |
| I understand that before the first day of attendance by my child, I will provide proof of completed age-appropriate immunizations or exemption from immunizations. To my knowledge, immunizations are all up to date and my child is in good health and free of disabilities that would endanger them or others in the programs. | |
| I understand falsifying or omission of information on this enrollment form may be cause for dismissal from the program. | |
| I understand the financial policies and that failure to abide by these policies could result in removal from the program. | |
| I agree to the release of information between the school and afterschool staff as needed in regards to my child's school work and behavior as needed. | |
| Unless otherwise specified in writing, I give consent to the staff and/or agents of funders and Unleashing Potential to interview/photograph/videotape my child. I understand that the interview and photograph/videotape information may be used in local and national publications and websites, including advertisements.<br>☐ I do give consent.<br>☐ I do not give consent. | |
| I understand that I may request notice at initial enrollment or any time thereafter whether there are children currently enrolled in or attending the facility for whom an immunization exemption has been filed. | |
| ☐ I do give permission for field trips/excursions. I understand I will be notified in advance when they are planned.<br>☐ I do not give permission for field trips/excursions. I understand I will be notified in advance when they are planned. | |
| ☐ I do give permission for the facility to transport my child.<br>☐ I do not give permission for the facility to transport my child. | |
| **Parent/Guardian Signature** | **Date:** |
| | |

### Club Activity Release

**I give my child permission to attend the following club/activity. I understand that my child will not be released to a club/activity if this form is not complete. I further understand that while my child is in the club/activity, they are the responsibility of the club/activity leader and not Unleashing Potential.**

☐ My child ***does not*** attend club/activity afterschool outside of Unleashing Potential.

☐ My child ***does*** attend club/activity afterschool outside of Unleashing Potential.

**Name of Club/Activity**: _____

**Days of Club/Activity:** ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

**Time of Club/Activity:** from _____:_____ to _____:_____pm

**Dates of Activity**: Start date: _____ End Date_____

**Parent's Signature**_____**Date:**_____

# Client Rights & Responsibilities

***Special Note: Unleashing Potential has defined its "Client" as the Parents whose child (ren) receives services through our childcare and youth development programs exclusive of young adults, ages 18 - 24.***

## Unleashing Potential (UP) Clients have the right to:

- Be informed of their rights and responsibilities
- Be provided with sufficient information to make an informed choice about using the organization and its services
- Fair and Equitable treatment including:
  a. the right to receive services in a non-discriminatory manner
  b. the consistent enforcement of program rules and expectations
  c. the right to receive services that exemplifies dignity, respect, and is responsive to cultural and linguistic differences
- Be safe in the agency's service environments
- Written and oral communication in the languages of the major population groups served
- The provision of, or arranging for, communication assistance for persons with special needs who have difficulty making their service needs known
- Participate in all service decisions; receiving service in a manner that is non-coercive and that protects the person's right to self-determination
- Request a review of their care
- Refuse any service and be informed about the consequences of such refusal, which can include discharge
- Receive a schedule of any applicable fees and estimated or actual expenses and are informed prior to service delivery about: the amount that will be charged; when fees or co-payments are charged, changed, refunded, waived, or reduced; the manner and timing of payment; and the consequences of nonpayment.
- Confidentiality and privacy re: services rendered unless a legal court order requests such information
- Be informed on how to lodge complaints or grievances

**As a client of Unleashing Potential, I recognize my responsibility to:**

- Participate in services specified in my plan including compliance with program rules and regulations.
- Not engage in violent or destructive behavior
- Honor the confidentiality of others during group activities
- Provide relevant information as a provision for receiving services and participating in service decisions

_____ _____

**Client Signature** **Date**

Copy: Client File
Relevance: COA - CR1

# Attach Immunization Records