

NYS 21<sup>st</sup> Century Community Learning Centers (CCLC)  
Creating Rural Opportunities Partnership (CROP) Enrollment Form

School Name \_\_\_\_\_

Year: \_\_\_\_\_

**Student's Full Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Gender:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Language(s) Spoken at Home \_\_\_\_\_

Racial/Ethnic Group: ☐ American Indian/Alaska Native ☐ Black or African American ☐ Hispanic or Latino ☐ Asian  
☐ White ☐ Native Hawaiian/Pacific Islander ☐ Two or more races ☐ Other

Student's Primary Teacher: \_\_\_\_\_

Name of Person Enrolling Student: \_\_\_\_\_ Relationship: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Student's Home Address (If different from above): \_\_\_\_\_

**Mother/Guardian** – Phone #: \_\_\_\_\_ Work # \_\_\_\_\_

Email address: \_\_\_\_\_

**Father/Guardian** – Phone #: \_\_\_\_\_ Work #: \_\_\_\_\_

Email address: \_\_\_\_\_

**Emergency Contacts /Authorized Adults for Student Pickup**

Name	Phone	Relationship to child	May this person pick up your child? (yes/no)	
			For Emergency?	For Daily Dismissal?

**Is there anyone who MAY NOT pick up your child? If so, please list below:**

Name	Relationship to child

**Bus Pickup/Dropoff Locations** (If your student will require bus transportation)

Location (home, babysitter, etc.)	Physical Address

I give my child permission to walk alone at dismissal: ☐ Yes ☐ No

**Student Attendance and Arrival/Dismissal Plan: Summer** ☐ **School Year** ☐

✓	Day	Arrive via... (bus from ????, parent dropoff, walk, etc.)	Early pick up (Time)	Depart at regular time via... (parent pick up, bus to ????, walk, etc.)
	Monday			
	Tuesday			
	Wednesday			
	Thursday			
	Friday			

**Please Note:** Any change in this dismissal plan on a daily, weekly, or permanent basis **MUST** be given to the Site Coordinator **IN WRITING** by the parent or guardian.

### Emergency Medical Information

If I cannot be reached in an emergency, I hereby give my permission to the physician/hospital selected by the CROP Program to secure proper medical treatment for my child.

Parent/Guardian Signature:

Date:

### Student's Health Information (All information is confidential and is used by the program staff to ensure the safety of students.)

Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list what the child is allergic to:  If yes, does your child need/use and EpiPen? <input type="checkbox"/> Yes* <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, does your child use an inhaler or other medication for their asthma? <input type="checkbox"/> Yes* <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, does your child need medication or blood glucose monitoring? <input type="checkbox"/> Yes* <input type="checkbox"/> No If yes, does your child have a prescription for glucagon? <input type="checkbox"/> Yes* <input type="checkbox"/> No
Seizure Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, does your child need medication for preventing or treating seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No
Vision Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, and your child needs aids at school other than wearing glasses or contacts, please describe:
Hearing Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, and your child needs aids at school other than wearing a hearing aid, please describe:
Physical Limitations	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is your child able to participate in physical education class at school with no limitations? <input type="checkbox"/> Yes <input type="checkbox"/> No
Other Medications	<input type="checkbox"/> Yes* <input type="checkbox"/> No	If yes, please list:

Does your child have special diet needs, other health needs, or behavioral/emotional needs? If yes, please describe:

\*Please note medications taken or administered at the program will need written parent/guardian consent and health care provider order. Please check with the Site Coordinator for further details.

## CROP STUDENT DATA REQUIREMENTS AND SURVEY/INTERVIEWS CONSENT

Creating Rural Opportunities Partnership (CROP) after-school program is funded by the 21<sup>st</sup> Century Community Learning Centers grant. This is a federal grant that requires evaluation and data collection to monitor the effectiveness of the after-school program and ensure its future success. Through evaluation, we hope to learn how after-school services help students, and how they can be improved to meet the grant requirements.

Any information that is collected will be used only to assess the after-school program and will not be made public. Participating in the evaluation will not affect your child in school, in the after-school program, or in any other way. We will not use your name or your child's name in any report.

I understand that my child's academic, behavioral, attendance, and engagement information will be shared with the New York State Education Department and its lawful contractors, to measure and evaluate the quality and implementation of the local 21<sup>st</sup> Century Community Learning Center (21<sup>st</sup> CCLC) program as well as the effectiveness of New York State's program in supporting student growth, as required by Title IV, Part B of the Every Student Succeeds Act (ESSA) [see general sections 4205 (b) and 4203 (14)].

- I give my child permission to enroll and participate in the 21<sup>st</sup> CCLC CROP Program. ☐ YES ☐ NO
- I understand the following agreements and consents are not pre-conditions for approval to participate in the 21<sup>st</sup> CCLC CROP Program. ☐ YES ☐ NO
- I give consent for my child to participate in interviews, the use of quotes, and the taking of photographs, movies, or videotapes by the CROP program staff. I also grant the CROP Program the right to edit, use, and reuse said products for non-profit purposes including use in print, on the internet, and all other forms of media. I also hereby release the CROP program and its agents and employees from all claims, demands, and liabilities whatsoever in connection with the above. ☐ YES ☐ NO
- I consent for my child to take part in field trips, away from the program site, under supervision. ☐ YES ☐ NO
- I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips. ☐ YES ☐ NO
- I provided information on my child's special needs to the program to assist in the safety of my child.  
☐ YES ☐ NO
- I understand that information regarding my child's special learning needs will be shared by my child's school with 21<sup>st</sup> CCLC CROP program staff on a need-to-know basis for my child's educational benefit. ☐ YES ☐ NO
- I agree to review and update this information whenever a change occurs and at least once every year.  
☐ YES ☐ NO
- I agree to talk with program staff about my child's progress and participation in the 21<sup>st</sup> CCLC CROP program.  
☐ YES ☐ NO
- If at any time I change my mind about my child's participation (any or all aspects), I will contact the site coordinator.  
☐ YES ☐ NO
- I prefer to receive ☐ paper or ☐ electronic communications from the CROP program.

**By signing below, I certify that all information (above) is true and correct to the best of my knowledge.**

**Name of Parent/Person** \_\_\_\_\_

**Signature**\_\_\_\_\_ **Date**\_\_\_\_\_

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