



Beacon Programs
Participant Registration Form

Beacon
PROGRAMS

All students must be registered for the Beacon program prior to enrollment. Staff shall review the forms with the parent/guardian to ensure that they are filled out completely, signed in the appropriate places and that they understand the contents thoroughly. **Participants must not be permitted to participate in the program until all of the forms are completed.**

Once the forms are completed, information must be entered on the Beacon online system at www.beacononline.org. These forms and other documents that are a part of the registration packet are to be placed in an individual folder that is prepared for each participant. This file is to be kept in a locked file drawer at the Beacon location and made accessible to DYCD staff.

The registration packet must consist of the following sections:

1. Participant Information
2. Pick Up Information
3. Parent/Guardian Information
4. Photo/Video Consent Form
5. Evaluation Form
6. Health Record

Please take note of the following when registering participants:

- No student will be permitted to attend the program prior to completing all registration materials.
- A copy of a current physical examination must be obtained from the parent/guardian and placed in the child's individual file. The medical form should be provided to the parent/guardian to be completed by the participants' health physician.
- All participants must be entered on the Beacon online system.



**DEPARTMENT OF YOUTH AND COMMUNITY DEVELOPMENT
BEACON PROGRAM**

Agency: _____

School: _____

Photo/Video Consent Form (To be completed by the parent or guardian)

I certify that I am the parent or legal guardian of _____, whose date of birth is _____, name of child
month/day/year

I understand that this after-school program features special events both in-school and away from school. Media representatives, newspaper and television reporters, photographers, and public-relations personnel may be present at these special events to record them. In some cases they may interview and/or photograph children who participate in these events. These photographs, videos, and interviews will only be used to promote this after-school program.

I give permission for my child to be photographed or otherwise recorded during after-school events and activities, and for any and all such photographs to be displayed by [NAME OF AGENCY, NAME OF AFTER-SCHOOL PROGRAM, SCHOOL] or The Department of Youth and Community Development in any medium (books, newsletters, web sites, etc.), whether now or hereafter known or developed.

SIGNATURE OF PARENT OR GUARDIAN

DATE

If you do not wish for your child to participate in the activities described above, please review this section of this form.

I DO NOT give permission for my child to be photographed or otherwise recorded during after-school events and activities. As a result, my child may not be able to participate in these events and activities.

SIGNATURE OF PARENT OR GUARDIAN

DATE



**DEPARTMENT OF YOUTH AND COMMUNITY DEVELOPMENT
BEACON PROGRAM**

Agency: _____

School: _____

**Parent Consent to Participate in the Evaluation of the
Beacon Program**

Dear Parent,

Your child, _____, is enrolled in the after school program at _____, which is supported by Department of Youth and Community Development (DYCD). In order to monitor the effectiveness of the after school program and ensure its future success, DYCD is conducting an ongoing evaluation. It is the intention of the evaluation to learn how these services help students and how they can be improved in order to meet the grant requirements.

Specifically we ask permission from parents to:

- Contact their children’s school and obtain records showing their progress, including information about enrollment, grades, citywide and statewide test scores, and attendance.
- Talk to teachers and after-school staff about children’s progress and participation in the after-school program, and review program records on participation in the after-school program.
- Survey and/or interview parents and children about the after-school program and its effects.

Any information we collect 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. At the end of the evaluation, we will destroy all records that include personal information. Participation in the study is completely voluntary and participants may withdraw at any time with no consequences.

Please select one of the options below and return this form to the program coordinator/director.

YES, I GIVE PERMISSION FOR MY CHILD TO PARTICIPATE. I have read the above information and I give permission for my child to participate in the evaluation of the after-school program. I also consent for DYCD to obtain my child's records and to interview program and school staff for evaluation purposes.

Signature _____

Date _____

*NO, I DO NOT WANT MY CHILD TO PARTICIPATE. I have read the above information and I **DO NOT** give permission for my child to participate in the evaluation of the after-school program.*

Signature _____

Date _____

If you have any questions about the evaluation contact the after school site coordinator.

Health Record Information

This side to be filled in by parent before presentation to a physician.

Name of program: _____ Beacon _____
Name of child: _____ /_____/_____
Birthdate _____ Sex M F
Child's address: _____ Phone: _____
Name of Parent/guardian: _____ Phone: _____
Place of Employment: Father (Guardian) _____ Phone: _____
Mother (Guardian) _____ Phone: _____
In case of emergency, notify: _____ Phone: _____
If parent or guardian are not available in an emergency, notify:
1. _____ Phone: _____
2. _____ Phone: _____
Important: Has this child been exposed to any communicable disease during the three weeks prior to beginning program?
 Yes No (If yes, state type of exposure: _____)

Health history: (Check, giving approximate dates)

Allergies

Diseases

Hay Fever _____	Chicken Pox _____	Ear Infections _____
Ivy poisoning, etc. _____	Measles _____	Rheumatic Fever _____
Insect stings _____	German Measles _____	Convulsion _____
Penicillin _____	Mumps _____	Diabetes _____
Other drugs _____	Other contagious illnesses _____	Behavior _____
		Asthma _____

Other past illnesses _____
Operations of serious injuries (dates) _____
Hospitalization (dates) _____
Chronic or recurring illness _____
Conditions that require activity to be restricted? _____
Appliance worn (glasses, contacts, etc.) _____
Medication taken _____
Insurance Carrier: _____ I.D.# / Medicaid #: _____

Providing this information will help us assist your child in the event of an emergency.

Consent for Emergency Medical Treatment

I do hereby give authority to the Beacon staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Signature Relationship Date

Please continue on the following page

Physical Examination - To be filled out by Physician - please note information on reverse side

Parent: This form must be renewed every 12 months. If submitting a copy of the form already on file with the school, the exam date must be no older than 6 months from the child's start date of the *Beacon* Program. The purpose of this health record is to provide the staff with pertinent information which will help to serve the needs of this child in the *Beacon* - an after school program..

Immunization history - this is a record of dates of basic immunization and most recent booster doses.

DpaP, DTP or TD	Date _____	Date _____	Date _____	Date _____
Polio	Date _____	Date _____	Date _____	Date _____
MMR	Date _____	Date _____	Date _____	Date _____
Hemophilus Influenzae tybe b	Date _____	Date _____	Date _____	Date _____
Hepatitis B	Date _____	Date _____	Date _____	Date _____
Varicella	Date _____	Date _____	Date _____	Date _____
Other _____	Date _____	Date _____	Date _____	Date _____

Medical Examination - To be filled out by a licensed physician - *Examination is acceptable when performed no more than 6 months prior to enrollment in Beacon.*
Code: S = Satisfactory; X = Not satisfactory (explain); O = Not examined

General Appearance _____

Height _____ Weight _____ Blood Pressure _____ Hgb. test (date) _____

Urinalysis (date) _____ Posture & spine _____ Throat – tonsils _____

Eyes _____ Vision _____ w/glasses _____ Extremities _____ Heart _____

Ears _____ Hearing _____ Feet _____ Lungs _____ Skin _____

Nose _____ Teeth _____ Abdomen _____ Hernia _____

Genitalia _____

Neurological findings _____

Describe abnormal findings and/or handicapping conditions _____

Has child ever received products containing horse serum? _____

Allergy (please specify): _____

Recommendations and restrictions:

 Special diet: _____

 Special medicine (specify): _____

 Is parent sending special medicine? _____

 Activity restrictions _____

General appraisal: _____

I have examined the person herein described, reviewed his/her health history and it is my opinion that he/she is physically able to engage in the *Beacon* after school program activities, except as noted above.

Physician's name (please print)

Examining physician's signature M.D.

Address _____ Telephone _____

Date of examination _____