Application

Process and Forms

Admissions materials to be submitted:

{check each box when completed}

- ☐ Application Form
- ☐ Parent/Guardian Identification
- ☐ Recent Report Card or Progress Report
- ☐ Information Regarding Incarcerated Parent
- ☐ Copy of Physical Exam
- ☐ Two Emergency Contacts
- ☐ Mentor Information Completed

Admissions
Process and Materials

Please read all instructions carefully and complete all sections of the application in its entirety.

Please deliver or mail your application and other materials in a single large envelope with the correct amount of postage to:

Children of Promise, NYC – Admissions
600 Lafayette Avenue, 6th Floor
Brooklyn, New York 11216

The following application materials *MUST* be submitted:

I. Application Form

- ☑ Complete carefully and sign

II. Picture ID of Child's Caregiver

- ☑ Driver's License
- ☑ United States Passport
- ☑ United States Military card
- ☑ Non United States passport

III. Official report card or most recent progress report

IV. Documentation on facility of the imprisoned parent

V. Physical copy or most recent physician's visit

- ☑ Copy from child's school accepted

Any questions, please call: 718.483.9290
All application materials become permanent property of *Children of Promise, NYC.*

OFFICE USE ONLY:

MENTORPRO IDENTIFICATION NO.:

____

OFFICE USE ONLY:

OPEN HOUSE: _______

CAREER INTEREST SURVEY: ______

GROUP SESSION: _______

ONE-TO-ONE: _______

PLACEMENT DATE {MATCH}: ______

PURPOSE OF APPLICATION:

☐ AFTERSCHOOL ☐ SUMMER DAY CAMP

PLEASE **PRINT CLEARLY** AND FILL OUT **COMPLETELY**
USE A BLACK OR BLUE PEN

I. GUARDIAN'S PERSONAL INFORMATION

LAST NAME: ____________________________ FIRST NAME: ____________________________ MIDDLE INITIAL: _______

MAIDEN OR FORMER NAME: ____

ADDRESS____ APARTMENT: ______________________________

CITY: ____ STATE: ____________________ ZIP: ________________

E-MAIL ADDRESS (IF APPLICABLE): ____

HOME PHONE: (_________)__________________________________ CELL PHONE: (_________)____________________________

DATE OF BIRTH (MM/DD/YY): _ _/_ _/_ _ GENDER: ☐FEMALE ☐MALE SOCIAL SECURITY NUMBER: _ _ _-_ _-_ _ _ _

RELATION TO CHILD: ☐ MOTHER ☐ FATHER ☐ GRANDPARENT ☐ OTHER: ______________________

II. PLEASE LIST THE CHILD(REN) IN THE HOUSEHOLD

LAST NAME: ______________________________ FIRST NAME: ____________________________ MIDDLE INITIAL: _______

DATE OF BIRTH (MM/DD/YY): _ _/_ _/_ _ GENDER: ☐FEMALE ☐MALE SCHOOL: ________________________

GRADE: ______

LAST NAME: ______________________________ FIRST NAME: ____________________________ MIDDLE INITIAL: _______

DATE OF BIRTH (MM/DD/YY): _ _/_ _/_ _ GENDER: ☐FEMALE ☐MALE SCHOOL: ________________________

GRADE: ______

LAST NAME: ______________________________ FIRST NAME: ____________________________ MIDDLE INITIAL: _______

DATE OF BIRTH (MM/DD/YY): _ _/_ _/_ _ GENDER: ☐FEMALE ☐MALE SCHOOL: ________________________

GRADE: ______

LAST NAME: ______________________________ FIRST NAME: ____________________________ MIDDLE INITIAL: _______

DATE OF BIRTH (MM/DD/YY): _ _/_ _/_ _ GENDER: ☐FEMALE ☐MALE SCHOOL: ________________________

GRADE: ______

III. Personal and household information for *Children of Promise, NYC*

Number of children in the household? _________

Are they currently a part of an afterschool or school based program? ☐ Yes ☐ No

If so, which one? ☐ YMCA ☐ SES ☐Boys & Girl's Club ☐Other: ___________________

Are you the head of household? ☐ Yes ☐ No

Are you a single parent? ☐ Yes ☐ No

Are you and or someone in your household ***currently*** receiving TANF or SSI? ☐ Yes, TANF ☐ Yes, SSI ☐ No

IV. Household Composition

Please list any additional members of your household

Name	Age	Gender	Relationship

V. Youth's Medical History

Name of Primary Care Physician: ________________________________ Office Number: ______________________

Medical Insurance Provider: ___________________________________

Does your child have any of the following, please check all appropriate boxes:

☐ Allergies ☐ Diabetes ☐ Other: ____

☐ Asthma ☐ Rheumatoid Arthritis

Is your child on any medication? ☐ Yes ☐ No

If yes, indicate medication: ____

Is your child currently receiving counseling service? ☐ Yes ☐ No

If yes, what type of counseling?

☐ Individual ☐ Group ☐ Family ☐ Behavior ☐ Other: ____________________________

Therapist's Name: ___________________________________ Phone: _________________________________

Counseling Start Date: ______________________________ Counseling End Date:______________________

VI. Statistical information *(for statistical purposes only)*

Is English your primary language? ☐ **Yes** ☐ **No**

If no, please specify what your primary language is: ____________________

If you wish to be identified as a member of any of the following groups, *please check one*

☐ African-American	☐ Native American	☐ South Asian
☐ Hispanic	☐ Caucasian, non-Hispanic	☐ East Asian
☐ Asian or Pacific Islander	☐ Other/Unknown ____________________	

VII (A). Mentorship Program – Parent/Guardian Preference

Parent/Guardian Preference: Please check the appropriate box to indicate your response.

Do you have a preference for the nationality of the mentor?	☐ Yes	☐ No
Do you have a preference for the primary religion of the mentor?	☐ Yes	☐ No
Do you prefer a mentor that is a non-smoker?	☐ Yes	☐ No
Do you have a preference as to the sexual orientation of the mentor?	☐ Yes	☐ No

VII (B). Mentorship Program – Types of challenges

Academic/School

☐Attendance

☐Grades

Youth with Disabilities

☐Special Education

☐ Mental Health

☐Physical Disabilities

☐ Communication

☐ Social

☐ Other: ____________

Behavior

☐ Aggression

☐ Anger Management

☐ Attention Deficit (Hyperactivity)

☐ Attitude

☐ Delinquency

☐ Self Control

☐ Other: ____________

Personal

☐ Anxiety

☐ Confidence

☐ Depression

☐ Isolation/Lack of Support

☐ Self Esteem

☐ Other: ____________

VIII. Work Related Experience

Are you currently employed? ☐ Yes ☐ No

Are you currently in school? ☐ Yes ☐ No

If employed, please outline employment history below.

Company/Organization	Title/Duties	Years employed	Other Information

IX. Special Skills

Please list any special skills that you would like to share with *Children of Promise, NYC.*

1) ______________________________
2) ______________________________
3) ______________________________
4) ______________________________

X. Incarcerated Parent information

Is the mother or father incarcerated? ☐ Mother ☐ Father ☐ Both

Name of Parent: ____________________ Name of Correctional Facility: ____________________

Prisoner Identification Number: ____________________

When was he/she incarcerated and length of sentence? ____________________

Has the child ever visited the incarcerated parent? ☐ Yes ☐ No

If so, when was the last visit by the child? ____________________

Was the parent and child separated prior to the incarceration? ____________________

What was the relationship (between parent and child) prior to the incarceration? ____________________

Is the incarcerated parent in contact with the child? ____________________

XI. Emergency Contacts

In the event the parent/guardian cannot be reached, *CPNYC* staff will contact the people listed below in order they are listed, until someone is reached. The person(s) listed should be individuals who can: 1) give permission to administer health care, 2) pick your child up, if your child is ill, or 3) give advice about caring for your child.

Last Name: ______________________________ First Name: ______________________________

Address: ______________________________ Apartment: ______________________________

City: ______________________________ State: _______________ Zip: ____________

Home phone: (______)____________________ Cell phone: (______)____________________

Work phone: (______)____________________ Relationship to child: ____________________

Last Name: ______________________________ First Name: ______________________________

Address: ______________________________ Apartment: ______________________________

City: ______________________________ State: _______________ Zip: ____________

Home phone: (______)____________________ Cell phone: (______)____________________

Work phone: (______)____________________ Relationship to child: ____________________

Last Name: ______________________________ First Name: ______________________________

Address: ______________________________ Apartment: ______________________________

City: ______________________________ State: _______________ Zip: ____________

Home phone: (______)____________________ Cell phone: (______)____________________

Work phone: (______)____________________ Relationship to child: ____________________

Last Name: ______________________________ First Name: ______________________________

Address: ______________________________ Apartment: ______________________________

City: ______________________________ State: _______________ Zip: ____________

Home phone: (______)____________________ Cell phone: (______)____________________

Work phone: (______)____________________ Relationship to child: ____________________

XII. Read and carefully sign

Equal Opportunity All applicants will be given consideration. Answers to questions on this form will not be used to discriminate against any candidate.

I certify that I have read and understand the information in this application and that the information I have supplied is true and complete to the best of my knowledge. Applicants found to have supplied false information will be denied admission, or if admitted, face immediate disenrollment.

Parent/Guardian Signature: ______________________________ **Date:** ____________

I am aware the CPNYC offers counseling services and permit my child to participate and receive these services.

Parent/Guardian Signature: ______________________________ **Date:** ____________

I am aware that CPNYC offers the opportunity for participants to write their incarcerated parent. I give my child permission to participate in this activity.

Parent/Guardian Signature: ______________________________ **Date:** ____________

Occasionally photos may be taken during classes and other activities (i.e., field trips) to display the activities and services offered by Children of Promise, NYC. I hereby give CPNYC permission to use such images of myself and/or my child(ren) in activities for public relations, marketing and other purposes.

Parent/Guardian Signature: ______________________________ **Date:** ____________

My child has permission to walk home from the CPNYC after school program, therefore, I authorize she/he to sign themselves out of the program.

Parent/Guardian Signature: ______________________________ **Date:** ____________

XIII. How did you find out about *Children of Promise, NYC?*

Check all that apply:

☐ Letter mailed home ☐ Door hanger **[at home]**

☐ Imprisoned parent ☐ Post card **[at train station]**

- **Referred by:** ☐ Friend ☐ Family ☐ Other: __________
- **Search engine:** ☐ Google ☐ Yahoo ☐ Other: __________
- **Referred from a partnering agency:** ☐ Prison fellowship **[Angel Tree Program]** ☐ School Personnel ☐ Other: ______________________

XIV. Medical Statement of Child in After School Programming

To be completed by licensed physician, physician's assistant or nurse practitioner.

Name of Child: ____

Date of Birth: ____

Date of Examination: ____

XV. Immunization required for entry into after school program.

Medical Exemption – The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s).

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria And Tetanus and acellular Pertussis (DTaP)	1st Date	2nd Date	3rd Date	4th Date	5th Date
Polio (IPV or OPV)	1st Date	2nd Date	3rd Date	4th Date	
Haemophilus influenza type B (Hib)	1st Date	2nd Date	3rd Date	4th Date **OR** 1st Date (if given on or after 15 months of age)	
Hepatitis B	1st Date	2nd Date	3rd Date	4th Date	
Measles, Mumps and Rubella (MMR)	1st Date	2nd Date			
Varicella (also known as Chicken Pox)	1st Date	2nd Date			

XVI. Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A.

Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:

XVII. Tests

Tuberculin Test Date: _____/_____/___________ Mantoux Results: ☐ Positive ☐ Negative _____________ mm

TB Tests are at the physicians discretion.

If positive, or if x-ray ordered, attach physician's statement documenting treatment follow-up.

Lead Screening Date: _____/_____/___________

Attach lead level statement

Lead Screening (include All Dates and Results)

1 year _____/_____/_________ Result: ____________________ mcg/dl ☐ Venous ☐Capillary

2 years _____/_____/_________ Result: ____________________ mcg/dl ☐ Venous ☐ Capillary

Most recent date of lead screening (if different from above):

_____/_____/_________ Result: ____________________ mcg/dl ☐ Venous ☐ Capillary

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely. If the child has not been tested for lead, the after school program provider may not exclude the child from after school programming, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

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XVIII. Medical Statement of Child in After School Programming {continued}

Health specifics	Comments
Are there allergies? ☐ Yes ☐ No [Specify allergies on the line provided below] ______________________________	
Is medication regularly taken? ☐ Yes ☐ No [Specify drug and condition on the line provided below] ______________________________	
Is a special diet required? ☐ Yes ☐ No [Specify diet and condition on the line provided below] ______________________________	
Are there any hearing, visual, or dental conditions requiring special attention? ☐ Yes ☐ No	
Are there any medical or developmental Condition(s) requiring special attention? ☐ Yes ☐ No	

XIX. Summary of Physical Exam

1) Include special recommendations to after school providers

____

____

____

2) On the basis of my findings as indicated above and on my knowledge of the named child, I find the following:

☐ he/she **is** free from contagious and communicable disease and is able to participate in after school programming.

☐ he/she **is not** free from contagious and communicable disease and is able to participate in after school programming.

______________________________ ______________________________

Signature of Examiner Print Name and Title

(________)______________________________ ______________________________

Phone Date

Religious Exemptions

Public Health law Section 2164 allows a child to be religiously exempted from immunization. A written and signed statement from a parent or guardian of the child stating that they object of the immunization of their child due to their sincere and genuine religious beliefs should be submitted to the after school program owner, operator or administrator who shall determine whether the statement of religious belief is acceptable.

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