

**CATHOLIC SOCIAL SERVICES OUT-OF-SCHOOL-TIME PROGRAM
INTAKE / DISCHARGE FORM**

Provider/Site (code): _____ Intake Date: _____

Child's Name: _____ Date of Birth: _____

Child's Social Security Number: _____

Child's Pupil Identification Number: _____ (public school only)

Child's School: _____ Child's Gender: Male

Child's Grade: _____ Female

Caregiver's Name: _____

Caregiver's Relationship to Child (mother, uncle, etc.): _____

Caregiver's Phone Number: _____ Work Phone Number: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Phone Number: _____

Child's Race: African American Asian or Pacific Islander Latino/Latina
 White Multi-Ethnic Other (specify)

Child's Special Needs: Deaf/Hard of Hearing Developmentally Delayed Homeless
 Behavioral/Mental Health Substance Abuse Linguistic Minority
 Other (specify): _____

Funding Source Eligibility Status:

TANF Eligible: Yes No If Yes check all that apply: Assistance Recipient
 At or below 400% of Federal Poverty Level At or below 235% of Federal Poverty Level

Eligible: Yes No Other Status (please explain): _____

Please make sure all required paperwork for eligible status accompanies the Intake Form.

Date Informed Consent Received: _____ Date Health Assessment Form Received: _____

Date DPW Emergency / Parental Consent Form Received: _____

Discharge Date: _____

Reason for Discharge: Moved Medical Family Situation Poor Attendance
 Outside Activity Participation Behavioral Other (please explain): _____

EMERGENCY CONTACT FORM

EMERGENCY CONTACT/PARENTAL CONSENT FORM

CHILD'S NAME		BIRTH DATE	
ADDRESS			
MOTHER'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER	
ADDRESS			
BUSINESS NAME		BUSINESS TELEPHONE NUMBER	
ADDRESS			
FATHER'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER	
ADDRESS			
BUSINESS NAME		BUSINESS TELEPHONE NUMBER	
ADDRESS			
EMERGENCY CONTACT PERSON (S)		TELEPHONE NUMBER WHEN CHILD IS IN CARE	
1.			
2.			
3.			
PERSON (S) TO WHOM CHILD MAY BE RELEASED	ADDRESS	TELEPHONE NUMBER WHEN CHILD IS IN CARE	
1.			
2.			
3.			
NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER		TELEPHONE NUMBER	
ADDRESS			
SPECIAL DISABILITIES (IF ANY)		ALLERGIES (INCLUDING MEDICATION REACTION)	
MEDICAL OR DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION		MEDICAL SPECIAL CONDITIONS	
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD			
HEALTH INSURANCE COVERAGE FOR CHILD OR MEDICAL ASSISTANCE BENEFITS		POLICY NUMBER (REQUIRED)	
PARENT'S SIGNATURE REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT (must sign all 6 boxes)			
OBTAINING EMERGENCY MEDICAL CARE		ADMIN. OF MINOR FIRST-AID PROCEDURE	
WALKS AND TRIPS		SWIMMING	
TRANSPORTATION BY THE FACULTY		WADING	

SIGNATURE OF PARENT OR GUARDIAN

DATE

SIGNATURE OF PARENT OR GUARDIAN

DATE

FREQUENTLY ASKED QUESTIONS

Children's Investment Strategy Informed Consent Form [\(next page\)](#)

****Question: Why am I asked to sign this form?***

Answer: Children need safe and constructive activities when they are out of school. That is why increasing the number of quality and affordable programs for children and youth is such an important part of the Mayor's Children's Investment Strategy (CIS). Research tells us that good non-school hours programs help children do better in school. We want to make sure that our programs really are helping our children. To do that, the CIS needs your permission to collect information regarding your child's school performance. We may collect grades, standardized tests, achievement levels, report cards, school attendance, suspensions, and other relevant records.

****Question: Will information about my child be shared with others?***

Answer: We will not report on any individual children. We will not share your child's school information with any individual, group, or agency outside of CIS. We want you to know that your child's school information will be added to the school information from all the other children who participate in your child's CIS program. We will be looking at and reporting on that pool of information, and not at each individual child's progress.

****Question: What am I really agreeing to by signing the form?***

Answer: When you sign the informed consent form you agree:

- To let your child answer questions about the non-school hours program or community.
- To let your child's school give his/her records to the Children's Investment Strategy.
- That the CIS program gave you information about you and your child's rights.
- To not hold the City of Philadelphia, the Children's Investment Strategy, Philadelphia Safe and Sound, Philadelphia Health Management Corporation, and Catholic Social Services responsible for injuries and/or damages to my child's person and/or property.

****Question: Does my signature provide one-time permission or ongoing permission?***

Answer: Your permission remains valid for one year unless you revoke your consent in writing or until your child leaves the non-school hour's program.

CHILDREN'S INVESTMENT STRATEGY
1835 Market Street, Suite 420, Philadelphia, PA 19103

INFORMED CONSENT FORM

The Children's Investment Strategy (CIS) is a Philadelphia effort to improve the well-being of children and youth through effective youth development activities during non-school hours and provide preventive services to strengthen families, particularly the relationship between parents and children. The success of CIS is related to the following:

- Children need safe and constructive activities when they are out of school.
- Increasing the number of quality and affordable non-school programs is a part of the Mayor's Children's investment Strategy (CIS)
- Good non-school hours programs will help children do better in school.
- We need to see if children who attend non-school hours programs are doing better in school.
- The CIS needs your permission to collect information regarding your child's school performance.
- We may collect grades, standardized test information, achievement levels, report cards school attendance, suspension, and other school relevant records.
- We will not share your child's school information with any agency outside of CIS.
- Your child's school information will be added to the school information from all other children who participate in your child's non-school hours program.
- We will report information by non-school hours program, not by individual children. No one will be able to use this information to identify your child.

When you sign the informed consent form you voluntarily give consent and authorization that will remain valid for ONE Year from the date signed:

- To let your child answer questions about the non-school hours program or community
- To let your child's school give his/her records to the Children's Investment Strategy
- That the non-school hours program gave you information about you and your child's rights
- That your child will be supervised by professional staff.

I understand that the Buckley Amendment to the Family Education Rights and Privacy Act of 1974 guarantees that I/my child's educational records only to IS and to any corresponding partner agency or agencies with which I/my child will be placed or referred by CIS.

I understand that this information will not be provided to any entity other than those indicated above. I agree not to hold the City of Philadelphia, The Children's Investment Strategy, Philadelphia Health Management Corporation (PHMC), and Catholic Social Services responsible for injuries and/or damages to my child's person and/or property.

Youth's Name: _____ SS# _____

Youth's School and Grade: _____ DOB _____

Time my child will arrive at the CIS Program: _____ 8:00am _____

Time my child will depart from the CIS Program: _____ 6:00pm _____

Parent's/Guardian's Signature: _____ Date: _____

(If youth is under age 18)

Provider Witness Signature: _____ Date: _____

Provider Agency Name: Catholic Social Services-St. Malachy's OST

235% MEANS TEST WORKSHEET

I. IDENTIFYING INFORMATION FOR "SERVICES FOR NON-PLACED CHILDREN"		
1. CHILD'S NAME (LAST, FIRST, M.I.)	2. SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
3. CHILD'S DATE OF BIRTH	4. CHILD'S SSN	5. COUNTY IDENTIFIER 51
6. PERSON WITH WHOM THE CHILD IS LIVING	7. RELATIONSHIP TO CHILD	8. SSN OF PERSON WITH WHOM CHILD IS LIVING
9. AGENCY NAME	10. PROGRAM NAME	11.

II. MEANS TEST FOR "SERVICES FOR NON-PLACED CHILDREN"			
1. Is the child/family receiving <input type="checkbox"/> TANF (Cash Assistance) <input type="checkbox"/> SSI <input type="checkbox"/> FOOD STAMPS <input type="checkbox"/> MEDICAID NONE <input type="checkbox"/> Case #: _____ If services are being received, proceed to question 5 and answer "YES." If response is "NONE," proceed to question 2.			
2. Is the child a U.S. Citizen or qualified alien? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, indicate source of citizenship information: <input type="checkbox"/> Birth Certificate, <input type="checkbox"/> INS, <input type="checkbox"/> Eligibility for TANF, SSI, Food Stamps, or Medicaid or <input type="checkbox"/> Self-Declaration			
3. Is the child under 18 years of age? <input type="checkbox"/> YES <input type="checkbox"/> NO			
4. In order to be eligible for "services for non-placed children," a child's/family's gross income may not exceed 235 percent of the Federal Poverty Level (FPL) for the family unit size. Using Table 1 below, provide a "YES" or "NO" in Column 4 in the corresponding row for the family size as to whether the child/family's income is <u>less than</u> the annual or monthly amount for the family size. (Family unit includes biological or adoptive parents, specified relatives, or non-relative court designated legal custodians and full, half, and/or adopted siblings living in the home under the age of 18 plus the TANF child). This is a self-declared means test. No verification except the response of the family is required.			
Table 1: 235 Percent of Federal Poverty Level			
(1) Family Unit Size	(2) 235% of FPL (Gross Annual)	(3) 235% of FPL (Gross Monthly)	(4) (YES or /NO)
1	Less than \$24,440	Less than \$2,037	
2	Less than \$32,900	Less than \$2,742	
3	Less than \$41,360	Less than \$3,447	
4	Less than \$49,820	Less than \$4,152	

Note: For family units of more than 4 members, add \$8,460 annually (Column 2) and \$705 monthly (Column 3) for each additional member and place the correct figures in the blank row at the bottom of Table 1

5. Is the child living in the home of a parent, other adult specified relative or a court designated legal custodian?
 YES NO

6. Is the child/family receiving one of the benefits in question 1 or answers to questions 2, 3, 4 and 5 are ALL "YES"?
 YES NO

If "YES," the child is eligible for TANF funding for services for non-placed children.

Means Test Administered for: Month: _____ Year: _____

6. Name of staff person administering this means test (Please Print) _____

7. Date this form was completed: _____

CATHOLIC SOCIAL SERVICES-OUT OF SCHOOL TIME PROGRAM

The Out of School Time Program (OST) is a collaborative Philadelphia effort of the City of Philadelphia Safe, Philadelphia Health Management Corporation and private provider agencies ("the CSS Organizations"), to improve the well-being of children and youth through effective youth development activities during non school hours and provide services to strengthen families, particularly the relationship between parents and children.

Parent or Guardian Consent Form

I hereby grant Catholic Social Services permission to display in the news media or electronically via the Internet or in other displays, the artwork created by my child in connection with the non-school hours programs provided through CSS. I consent to have my child's artwork, name, grade level, and school displayed by CSS, allowing this artwork and information to be viewed by the general public.

I also grant to Catholic Social Services permission to display in the news media or electronically via the Internet and in other displays, photographs, and/or video footage of my child taken in connection with his or her participation in the non-school hour programs provided through CSS.

Program Name: _____

Child's First and Last Name: _____

Parent/Guardian's First and Last Name: _____

Address: _____
Zip Code

Phone: _____ E-mail: _____

Parent/Guardian Signature: _____

Date: _____

Catholic Social Services
Out of School Time Program

Waiver and Release from Liability for Bus Trips

Site: _____ Time: _____

Where: _____ Cost: _____

Date: _____

I, _____ legal parent and/or guardian of

_____ hereby waive and release, indemnify, hold harmless and forever discharge *Catholic Social Services* and its employees, directors, administrators and affiliates, of and from any and all claims, demands, debts, contracts, expenses, law or equity, that my child has or may have, arising from or in any way related to my child's participation in any of the events or activities conducted by, or for the benefit of *Catholic Social Services*, provided that this waiver of liability does not apply to any acts of gross negligence, or intentional, willful, or wanton misconduct.

I hereby jointly or severally, waive, release, absolve, indemnify and agree to hold harmless any and all adults who supervise/chaperone this activity, other participants, and any of the above named parties' representatives, successors, supervisors, sponsors, and/or organizers, for any injury of any kind that Student sustains while traveling to, attending, and participating in the aforementioned Event, provided that said injuries are not the result of gross or willful negligence.

I likewise release from liability any person(s), bus company, or other transportation service transporting clients/children from Catholic Social Services, with the exception of gross negligence due either fully, or in part, to mechanical failure and/or operator error.

I waive my right to bring suit whether the injury be accidental or intentional in nature, whether the injury is immediately discovered or discovered at some future time, and regardless of the identity of the party inflicting injury. I have read and understand the above provisions. I agree to the above provisions voluntarily, intelligently, willingly and intentionally. I understand that I cannot withdraw this waiver without the consent of Catholic Social Services.

Legal Parent/Guardian Signature _____ Date _____

Parent's Daytime Phone Number _____

Emergency Contact & Phone Number _____

PARENT PERMISSION FORM

Catholic Social Services

**PARENT'S/GUARDIAN'S PERMISSION FORM FOR
CHILD'S/CHILDREN'S PARTICIPATION IN THE
OUT OF SCHOOL TIME PROGRAM**

I (we) as parent(s) or legal guardian(s) give permission for

(Child's Name)

(School)

to participate in the OST Program, which operates Monday through Friday, 8:00am to 6:00pm from June 2016 to mid-August 2016. I (we) understand that my (our) child(ren) will receive nutritious snack, and will participate fully in all the supervised and scheduled activities of the program. I (we) agree as the parent(s) or legal guardian(s) to notify staff in writing of any physical, medical, and/or dietary restrictions my (our) child(ren) may have.

I (we), parent(s)/guardian(s) and child(ren), understand and agree to abide by all rules and regulations herein this manual established by the administration/staff, for the safety, protection, and well-being of my (our) child(ren).

I (we) further assume all risk in full from my (our) child(ren)'s participation in the OST Program.

(Parent/Guardian's signature)

(Date)

Parent/Guardian Contract

The staff members of the OST program and you as a parent/guardian are committed to improving the educational potential of every child by working together to cooperatively raise student achievement levels. To that end, we jointly agree that:

I have read and understand the Program Handbook in its entirety and agree to adhere to its contents. In addition, I understand that the CSS OST Program will:

1. Supervise my child at all times.
2. Make my child feel welcomed, comfortable, and safe.
3. Implement a creative and enjoyable program.
4. Provide academic support and personal enrichment.
5. Allow time for creative activities and indoor/outdoor recreation.

AS THE LEGAL GUARDIAN I UNDERSTAND THAT I WILL:

- Drop my child off and pick him/her up in a timely fashion (unless a child sign out declaration form is signed)
- Contact the OST Office if I will be picking my son/daughter up early (before the designated dismissal time). I understand that early pick-ups disrupt programming and should occur only in an emergency.
- Physically sign my child out if he/she is to be picked up (unless a child declaration form is signed). I understand that due to safety reasons, the OST Program will not send children out to the parking lot.
- Update program staff of address/telephone number changes.
- Contact the OST Program if my child will not be participating on any given day or will be picked up earlier than conclusion of activities.
- Complete and turn in necessary enrollment information.
- Sign, date and return behavioral forms on the following program day or my child may not return to the program.

Parent/Guardian: _____
(Please Print)

Parent/Guardian: _____
(Signature)

Date: _____

Staff Signature: _____

OST Program Rules

Please review these rules with your child(ren) prior to program attendance.

- 1. I will be respectful and polite to all people I interact with using “Please” and “Thank You”.**
- 2. I will be mindful and respectful of all property including space, toys, and equipment.**
- 3. I will clean up after myself.**
- 4. I will listen and follow all directions.**

Fighting, stealing, foul language, or other undesirable behavior will not be tolerated in the OST After- School/Summer Camp Program. Children will be given a warning for the first infraction. For the second infraction a written warning will be sent home for the Parent/Guardian to sign. Three write ups may result in suspension and/or dismissal from the program.

Parent/Guardian Signature: _____

Child's Signature: _____

Staff Signature: _____

**Public Health Management Corporation
Out-of-School Time Project**

**Consent to Collect Information
July 1, 2015 to June 30, 2016**

Agency Name

Program Location and Model

Purpose:

The City of Philadelphia's Department of Human Services (DHS) funds over 200 after-school programs through the Out-of-School Time (OST) program. The City has a contract with Public Health Management Corporation (PHMC). PHMC manages the OST program your child attends. When you enroll your child in OST, PHMC will collect information from you to help manage the program. If you agree, we will also ask you and your children questions about OST to make the program better.

Process:

When you sign-up for an OST program, PHMC will ask you some questions about your child, such as his name, age and address. You will complete this information on the program's registration forms. This information will be entered into a database at PHMC. Staff at PHMC and the City will be able to see this information and use it to improve the OST program. OST staff may also visit the program and talk to your child about being at that program. This is a basic part of OST for every child and every after-school site.

To learn more about your experience with OST, PHMC may ask you and your child to complete short surveys. These surveys will be given at the start and at the end of the school year during regular after-school time. The survey will ask questions about what you and your child think about the program.

Information Privacy and Sharing:

The information that we collect about your child will not be shared with anyone outside of the OST program. All of the information is stored in a database that is protected by a password. Only approved staff at PHMC or the City can see the information.

We will never share any single child's answers. We will only share results from the survey for the OST program as a whole.

Voluntary Surveys:

You can decide if you want your child to participate in the OST surveys. You can decide not to participate. This will not in any way affect your child's chance to enroll in the program.

Questions:

If you have any questions about this form, you may contact: Rachel Viddy at PHMC, 215-825-8201 or ost@phmc.org.

PLEASE CHECK ONE OF THE BOXES and SIGN BELOW:

- Agreement to Participate:** I have read and understand this form. I agree to allow my child to answer the surveys.
- Refusal to Participate:** I have read and understand this form. I do NOT give permission for my child to answer the surveys.

Child's Name

Parent/Guardian's Name

Parent/Guardian's Signature

Date

CATHOLIC SOCIAL SERVICES-OST PROGRAM

PERMISSION TO WALK HOME AUTHORIZATION

(5TH GRADE ONLY)

I, _____ hereby give my child, _____
(Parent/Guardian) (Child's Name)

permission to sign themselves out concerning the daily attendance sheet and walk home from the OST Program. I, therefore, will assume all risk in full that my child may incur once they have left the program.

Parent/Guardian's Signature

Date

Parent/Guardian's Signature

Date



CSS OST Program
www.cssoutofschooltime.org
TUITION AGREEMENT

Year: _____ Summer/School Year

Date of Enrollment: _____

*In case of emergency, I give permission for my child(ren) to be released to the people named on the emergency contact on file and those listed below. (Print name, relationship, and phone #)

1. _____ 2. _____

I would like to enroll my child(ren) _____ in CSS St. Malachy's OST program.
Hours of operation Monday-Friday 3:00-6:00 p.m. (School Year); 8:00 am-6:00 pm (Summer Camp)

My Child's weekly schedule will be:

Monday _____ 3:00pm to _____ 6:00pm
Tuesday _____ 3:00pm to _____ 6:00pm
Wednesday _____ 3:00pm to _____ 6:00pm
Thursday _____ 3:00pm to _____ 6:00pm
Friday _____ 3:00pm to _____ 6:00pm

My child(ren) will attend full day yes/no
My child(ren) will attend half days yes/no

Payment of fees:

I agree to pay (on Monday or Friday of each week that my child attends) the sum of \$ _____

Tuition Rates/Fees:

School Year: \$307.00 weekly, per child
Summer Camp: \$307.00 weekly, per child
Note Scholarships are available.

Should the fee become delinquent by two or more weeks, a communication will be sent to remind parents to pay all back fees immediately. Parents unable to pay weekly fee MUST talk to the OST Director to come up with an alternative payment plan and schedule. Failure to do this may lead to the withdrawal of my child until the entire overdue balance is paid in full or an alternative payment plan and schedule is agreed upon. I also understand that my child position will not be reserved in the group and will be unable to register for fall or summer enrollment unless balances are paid.

1. Cash Payment

I understand that St. Malachy's OST will not be held responsible for cash payment made without a receipt.

Child Health Assessment

Parents & Child Care Providers fill-in this part. Parents may write immunization dates, health professionals should verify and complete all data.

Child's Name: (Last)		(First)		Parent/Guardian:				
Date of Birth:		Home Phone:		Address:				
Child Care Facility Name:								
Facility Phone:		County:		Work Phone:				
<small>To Parents: Submission of this form to the child care provider implies consent for the child care provider to discuss the child's health with the child's clinician.</small>								
PA child care providers must document that enrolled children have received age appropriate health services and immunizations that meet the current schedule of the American Academy of Pediatrics 141 Northwest Point Blvd., Elk Grove Village, IL 60007. The schedule is available at <www.aap.org> or Faxback 847/758-0391 (document #9535 and #9807). Print copies provided by DPW have the schedule on the back of the form.								
Health history and medical information pertinent to routine child care and emergencies (describe, if any):				Date of most recent well-child exam:				
<input type="checkbox"/> NONE Allergies to food or medicine (describe, if any):				Do not omit any information. This form may be updated by health professional. (Initial and date new data.) Child care facility needs 2 copies.				
<input type="checkbox"/> NONE								
LENGTH/HEIGHT		WEIGHT		HEAD CIRCUMFERENCE				
IN/CM % ILE		LB/KG % ILE		(Birth to Age 2) (Beginning at age 3)				
				/				
PHYSICAL EXAMINATION			<input checked="" type="checkbox"/> = NORMAL					
Head/Ears/Eyes/Nose/Throat			If ABNORMAL - COMMENTS					
Teeth								
Cardiorespiratory								
Abdomen/GI								
Genitalia/Breasts								
Extremities/Joints/Back/Chest								
Skin/Lymph Nodes								
Neurologic & Developmental								
IMMUNIZATIONS						DATE		
DTaP/Td						DATE		
POLIO			DATE					
HIB			DATE					
HEP B			DATE					
MMR			DATE					
VARICELLA			DATE					
PNEUMOCOCCAL			DATE					
OTHER			DATE					
SCREENING TESTS		DATE TEST DONE		NOTE HERE IF RESULTS ARE PENDING OR ABNORMAL				
LEAD								
ANEMIA (HGB/HCT)								
URINALYSIS (UA) (at age 5)								
HEARING (subjective until age 4)								
VISION (subjective until age 3)								
PROFESSIONAL DENTAL EXAM								
Health Problems or Special Needs, Recommended Treatment/Medications/Special Care (attach additional sheets if necessary)								
<input type="checkbox"/> NONE				NEXT APPOINTMENT - MONTH/YEAR:				
Medical care Provider:			Signature of Physician or CPNP:					
Address:								
		Phone:		License Number:				
				Date Form Signed:				

VERBAL REQUEST FOR RELEASE OF CHILD

55 PA CODE CHAPTERS 3270.117(c) and 3280.117(c) and 3290.116(c)

**THIS FORM MUST BE COMPLETED TO DOCUMENT THE VERBAL REQUEST BY A PARENT FOR THE
RELEASE OF A CHILD TO A PERSON(S) NOT INDICATED ON THE AGREEMENT**
(CHAPTERS 3270.123(a)(5), 3270.124(b)(7); 3280.123(a)(5), 3280.124(b)(7); 3290.123(a)(5), 3290.124(b)(7)).

NAME OF CHILD	DATE	TIME
NAME OF REQUESTING PARENT	TELEPHONE NO. FROM WHICH PARENT IS CALLING	
NAME OF INDIVIDUAL TO WHOM THE CHILD IS TO BE RELEASED ➤		
NAME OF STAFF PERSON TAKING THE CALL ➤		

CALL THE ENROLLING PARENT BACK TO CONFIRM THE INFORMATION IF POSSIBLE

CONFIRMING PARENT	DATE
NAME OF STAFF PERSON CONFIRMING INFORMATION	TIME

<hr style="width: 80%; margin: 0 auto;"/> NAME OF STAFF PERSON RELEASING CHILD	<hr style="width: 80%; margin: 0 auto;"/> DATE
--	--

BE SURE TO ASK FOR IDENTIFICATION WHEN THE INDIVIDUAL ARRIVES TO PICK UP THE CHILD

CONSENT TO RELEASE EDUCATIONAL RECORDS

The City of Philadelphia
Out-of-School Time Project
CONSENT TO RELEASE EDUCATION RECORDS UNDER FERPA

Student: _____

Student ID #: _____

The Out-of-School Time Project ("OST") is a Philadelphia effort to improve the well-being of children and youth through effective academic support, enrichment and youth development activities during non-school hours. OST programming provides safe, constructive activities to children when they are not in school, and has been demonstrated to improve in-school performance.

In order to assess and improve the quality of OST programs, The City of Philadelphia Department of Human Services (the "City") asks for permission to collect personally identifiable information from education records regarding children's school performance. The City will collect standardized test scores, report cards and school attendance, disciplinary and other relevant school records ("education records"). The City will use these education records to measure the impact of OST programming on children's school performance and to improve the quality of those programs.

I am the parent or guardian of the student named above ("Student"). As authorized by applicable law, including but not limited to the Family Education Rights and Privacy Act, 20 U.S.C. 1232g, and 34 C.F.R. Part 99 ("FERPA"), I consent and authorize The School District of Philadelphia (the "School District") to release education records concerning the Student, including confidential records of the School District, to the City's Department of Human Services, the Public Health Management Corporation, and my Student's OST program ("Recipients").

The School District releases these education records in connection with the Student's participation in an OST program. The School District may disclose these education records only to the Recipients, and the Recipients may share this information only with other named Recipients, and with the Recipients' officers, staff, administrators and independent contractors under the Recipients' control. The Recipients may use these education records to research, study or evaluate OST programs.

If asked, the School District will provide me with a copy of the records disclosed.

FERPA and other applicable laws protect the confidentiality of and your right to privacy concerning the Student's education records. The Recipients shall keep all information concerning the Student confidential and private to the fullest extent provided by applicable laws, including FERPA. Neither The School District nor the Recipients require me to waive any rights under these laws, and I give my consent voluntarily.

Parent/Guardian Signature (or Student's signature,
if
Student is 18 years old or an emancipated minor)

Date

Name of school in which Student is currently enrolled

Student's Grade

Name of Student's OST Provider Agency

Student's Date of Birth

Name of Student's OST Provider Location