EmpowerSTEAM Summer Academy

EmpowerSTEAM Summer Academy 2020

STUDENT APPLICATION

empowersteam@ywcanca.org

(202)-626-0700 (P)

Student Information: (Please Print Clearly)

Name: (Last) _____ (First) _____ (Middle Initial) _____

Street Address: _____ Apt. #:_____

City: _____State: _____Zip Code: _____ County/Ward:_____

Primary Phone :(_____) _____ Cell Phone: (____) _____

Email: _____

Birthdate: (month/day/year) _____ Age: _____ Adult T-Shirt Size: XS S M L XL

Parent/Guardian Information:

Name: _____ Relationship to Student: _____

Home Phone: (_____)_____ Cell Phone: (____)_____

Work Phone: (_____)_____ E-mail: _____

Emergency Contact Information:

Name: _____ Relationship to Student: _____

Home Phone: (_____)_____ Other Phone: (_____)_____

Education:

School: _____ Grade Level: _____

Do you have an individual education plan? ( ) YES ( ) NO

Please indicate any physical or identified learning disabilities requiring special accommodations:

_____

_____

_____

Please indicate any health conditions or restrictions you think we should be aware of (including allergies)

_____

_____

_____

How did you hear about YWCA NCA's EmpowerSTEAM Summer Academy?

□ Family/Friend □ School/Employer □ Flier/Poster/Ad □ Other: Agency

□ Church □ Special Event □ Library □ Other: Return Student

Ethnicity (Check all that apply)

□ Asian
□ Hispanic or Latin
□ Black or African American
□ White
□ American Indian or Alaskan Native
□ Native Hawaiian or Other Pacific Islander

Language(s) spoken in the home other than English:

_____

Family Demographic Information: Public Assistance Status

□ None □ General Assistance

□ SSI □ Food Stamps

□ TANF Recipient □ Totally Disabled/SSDI

Family Demographic Information: Family Income

□ < $4,999 □ $5,000-$9,999 □ $10,000-$14,999

□ $15,000-$19,999 □ $20,000-$24,999 □ $25,000-40,999

□ >$41,000 □ SSI □ Not Available

Number of people in household: _____

General Information

Can you **commit** to participating in EmpowerSTEAM Summer Academy M-F, 9:00am-3pm, from

June 29- August 7? _____ **Yes** _____**No**

If no, please explain:

_____

_____

Transportation: I give my permission for the EmpowerSTEAM Summer Academy staff/volunteers to release my child to any of the people listed below:

Parent/Guardian: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Pick-up Person 3: _____ Phone: _____

"I certify that the information contained in this application is true and complete to the best of my knowledge"

_____ _____

Student Signature Date

_____ _____

Parent/Guardian Signature Date

Please mail, scan, fax, or email your completed application and signed parent consent forms to:

YWCA National Capital Area- SUMMER

2303 14th St., NW, Suite 100

Washington, DC 20009

T: 202-626-0700 F: 202-347-7381

empowersteam@ywcanca.org

- Selections are made on a first come, first serve basis. Preference is given to early applicants, DC residents and returning YWCA NCA participants. This camp is designed to spark interest in STEAM.
- Confirmation Email will be sent upon submission.
- All Parents must attend Mandatory Parent Orientation. (See Below)
- If you are unable to attend, you risk losing your seat to a student on the waitlist.

Mandatory Parent Orientation (must attend one session): Please check one.

○ **Tuesday, June 23rd – 7:00 pm- 8:30pm**
○ **Thursday, June 25th – 7:00 pm – 8:30pm**
○ **Saturday, June 27th-10:00 am – 11:30 am**

Revised. January 2020

EmpowerSTEAM Summer Academy

Release of Liability

I _____, release The YWCA National Capital Area and its staff (including volunteers) from any liability resulting from emotional and/or physical injury or other damages incurred while attending the EmpowerSTEAM Summer Academy located at the YWCA National Capital Area facility in Washington, DC , and any other program activities taking place outside of the YWCA premises, to the maximum extent permitted by law. I understand that I am solely responsible for my actions and that any incidents or damages that occur because of my actions are my sole responsibility. I also understand that if I am under the age of 18, I must have authorization from my legal guardian and that I and/or my guardian will be responsible for any damages occurring as a result of my willful, negligent or reckless behavior.

_____ _____

Student Signature Date

_____ _____

Parent Signature Date

_____ _____

Director/Manager Signature Date

Revised. January 2020

Student Contract

As a member of the EmpowerSTEAM Summer Academy, I pledge to:

1. Attend at least 24 out of the 29 regularly scheduled summer sessions.
2. Notify the Director/Manager of Youth Programs if I plan to be absent from a summer session in advance, whenever possible.
3. Respect and obey the directions of any adult advisor in the program.
4. Show respect, concern, goodwill and consideration toward everyone else—everyone is responsible for assuring that **no one feels "left out."**
5. Participate as a group in planned activities; i.e. discussions, physical activities and other team-oriented activities.
6. **NOT use my cell phone** while program sessions/activities are taking place.
7. Agree to ensure that the YWCA Empower STEAM Summer Academy facility be left in a clean and organized condition.

Consequences of Misbehavior:

I understand that if I break any of the above rules or disrespect an adult or another student in any way, the following actions will be taken:

1. Warning - a formal spoken warning and miss out on next group activity
2. Call to parents and final written warning
3. Expulsion from the EmpowerSTEAM Summer Academy

_____ _____

Student Signature Date

_____ _____

Parent Signature Date

_____ _____

Director/Coordinator Signature Date

Revised. January 2020

Parent Contract

The following information is important for the safety and protection of your child. Please read this information and sign below.

- I understand that I am NOT to leave my child at the YWCA National Capital Area unless an EmpowerSTEAM staff member or volunteer is present to receive and supervise my child.

- I understand that it is my child's responsibility to sign in at the time of drop off ***and*** sign my out at the time of pick-up. ***Sign-in/Sign-out sheets are available***

- I understand that my child will NOT be allowed to leave the program with an unauthorized person.***Any person authorized to pick up my child must be listed on the "Transportation Arrangements" for.***
- I understand that the YWCA NCA is required to report any suspected cases of child abuse or neglect to the appropriate authorities for investigation.

- I understand that YWCA NCA staff and volunteers are not allowed to babysit or transport children at any time outside the YWCA NCA facilities and program. ***If a violation of this policy is discovered, the YWCA NCA will take immediate disciplinary action toward staff and volunteers.***

- I understand that the YWCA NCA will do it's best to engage all youth in all activities for the duration of the program, however, the YWCA NCA has the right to expel any youth from the program for misbehavior that poses a threat to the safety of themselves or others.

I have read and understand the statements above regarding YWCA NCA policies and procedures.

_____ _____

Parent Signature Date

_____ _____

Director/Coordinator, Youth Programs Date

Revised. January 2020

EmpowerSTEAM Summer ACADEMY 2020

MANDATORY AUTHORIZATION FORM FOR STUDENTS

I hereby give permission for _____ to attend the EmpowerSTEAM Summer Academy during the period from **June 29th-August 7th, 2020.**

Please carefully read and initial each of the following statements:

_____ I understand my child will join approximately 100 other young, middle school- high school aged girls for the duration of the program. EmpowerSTEAM Summer Academy will be directed by staff of the YWCA National Capital Area and the EmpowerSTEAM Summer Academy at the YWCA NCA.

_____ I understand the mission of the EmpowerSTEAM Summer Academy revolves around the importance of empowering young girls through leadership opportunities, exploring STEM through hands-on activity, and fostering creative minds through art.

_____ I give permission for my child to participate in all program activities including, but not limited to: completing STEAM assessments/evaluations, physical activities, outdoor events, field trips, along with arts, themed events, inspirational forums, educational workshops and life seminars; unless the child's parent/guardian advises the Director/Manager of Youth Programs in writing that such activities are inadvisable. _____ **I do not give permission**

_____ I am assured that while at the EmpowerSTEAM Summer Academy, any activity requiring transportation via a motor vehicle will have a driver (automobile or van) 21 years of age or older. I release that driver of the YWCA NCA and the EmpowerSTEAM Summer Academy from responsibility should there be an accident in which my child is injured.

_____ I understand that I, or an emergency contact, will be called in the event of any major illness or injury. If my child needs immediate attention and there is not time to contact me or the emergency contact, I authorize any staff of the EmpowerSTEAM Summer Academy and/or any medical clinic, hospital or emergency facility to administer all medicines, prescription drugs and other medical remedies required for, or on behalf of, my child while said child is in attendance and participating at any of the functions or facilities of the EmpowerSTEAM Summer Academy.

_____ I specifically agree to advise the staff of the EmpowerSTEAM Summer Academy of all prescribed and required medicines, prescription drugs and other medical needs for my child on a medical form provided by the EmpowerSTEAM Summer Academy. I give my consent and authority for said staff and volunteers to administer such medications as prescribed by a physician. I further waive any claim on behalf of myself and my child pursuant to this paragraph.

_____ I further warrant that I have the authority to grant this medical authorization on behalf of this child and agree to hold the YWCA National Capital Area and/or medical clinic, hospital or emergency facility harmless by reason of my executing this medical authorization.

_____ I hereby give permission to the medical personnel selected by the YWCA NCA's the Director/Coordinator of Youth Programs to call for medical care to transport this child to a medical clinic, hospital or emergency facility and to order x-rays, routine tests and treatment for my child.

____ **I do not give permission**

_____ In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the YWCA NCA's Director/Coordinator of Youth Programs to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for my child.

_____ I understand that I will provide, or make provision for, my child's transportation to the drop-off and pick-up site at the YWCA NCA to attend the EmpowerSTEAM Summer Academy.

_____I understand that the YWCA NCA and the EmpowerSTEAM Summer Academy assumes no responsibility for my child's personal property.

_____ I understand that different venues of videotaping, photographing and audio taping will take place at the EmpowerSTEAM Summer Academy as part of functions specifically for the students, internal Youth Programs promotion and external media education. I hereby give EmpowerSTEAM Summer Academy full permission to record and use, copyright, reproduce, publish, distribute and exhibit my child's picture, likeness and/or voice by videotape, photograph or audiotape for purposes of recording the activities of EmpowerSTEAM Summer Academy to share internally with the students and other entities interested in EmpowerSTEAM Summer Academy and its mission.

_____ I understand that activities at the EmpowerSTEAM Summer Academy present certain foreseeable risks of injury to students even when due care is exercised by the YWCA NCA, its staff and volunteers. I, the parent/guardian agree to assume these risks and to take financial responsibility for any accidents, injuries to person, or damaged or broken property (excepting normal wear and tear) belonging to the YWCA NCA during participation in the EmpowerSTEAM Summer Academy.

_____ In consideration of my child being permitted to participate in activities at the YWCA NCA, to the maximum extent permitted by law, I, the parent/guardian, as legal custodian of the participant, agree to release the YWCA NCA and its staff (including volunteers) from any and all claims, damages, losses, and expenses for any personal injury which the participant may suffer, and from all claims for injuries, accidents, or property damage proximately caused by the participant

_____ I understand that neither I, nor my child, will receive any personal compensation for videotape photography or audiotaping of the child, but that my child's participation will serve an important purpose in creating memories and contribute to building awareness and promoting youth and girls empowerment in this country and around the world.

_____ I understand that I do not have to permit my child to be videotaped, photographed or audio taped unless I so desire for external use of the organization for media education purposes.

Name of Parent/Guardian authorized to complete form

Signature of Parent/Guardian authorized to complete form

Relation of person to child

Phone Number of person completing form

Date

Office Use Only :

Application Received	Parent forms Received	Entered in Database	Interviewed	Medical Forms	Optional Forms

YWCA National Capital Area

Quote/Photo Release Form

I _____ hereby □ **grant** □ **do not grant** the YWCA National Capital Area permission to use my likeness in a photograph or quote in any and all of its publications, including website entries, without payment or any other consideration.

If granted, I hereby irrevocably authorize the YWCA National Capital Area to copy, exhibit, publish or distribute such photographs for purposes of publicizing the YWCA National Capital Area's programs or for any other lawful purpose. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photographs.

If granted, I hereby hold harmless and release forever discharge the YWCA National Capital Area from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other person acting on my behalf or on behalf of my estate or may have by reason of this authorization.

If the person signing is **under age 18,** there must be consent by a parent or guardian, as follows:

I hereby certify that I am the parent or guardian of _____, named above, and do hereby give my consent without reservation to the foregoing on behalf of this person.

_____ _____

Parent/Guardian's Signature Date

_____

Parent/Guardian's Printed Name

If 18 years of age or older:

I am 18 years of age and am competent to contract in my own name. I have read this release before signing below and I fully understand the contents, meaning, and impact of this release.

_____ _____

Signature Date

Revised. January 2020

AUTHORIZATION FOR RELEASE OF HEALTH CARE RECORDS AND INFORMATION TO YWCA OF THE NATIONAL CAPITAL AREA

Name: _____ Last four digits SS#: _____

I hereby authorize: _____(the "Practice") to release a copy of my Protected Health Information as described below to: YWCA of the National Capital Area ("YWCA"), 2303 Fourteenth Street, NW, Suite 100 Washington, DC 20009.

Description of Protected Health Information to be released or disclosed: All Medical Records, Mental Health Records (except any psychotherapy notes), and Medication Records

IMPORTANT: I understand that unless I specifically request that such information not be disclosed, authorized disclosures may contain Protected Health Information containing diagnosis, treatment and other information regarding psychiatric and mental health treatment, substance abuse treatment, genetic information, and HIV and/or AIDS.

Please DO NOT RELEASE any of the following Protected Health Information from my medical record:

_____

The Protected Health Information indicated above is to be used and/or disclosed for the following purpose(s):

☐ For the YWCA to assess my educational needs and promote my progress in a YWCA Educational program

☐ Other:

This authorization will remain in effect for a period of one year, from ____/_____/_____ to ____/_____/_____. I understand that I may revoke this authorization at any time by notifying the Practice in writing, but that any such revocation will not have any effect on any actions that the Practice took before receiving my written revocation. I understand that if the Authorized Recipient named above is not subject to the federal privacy protection regulations, my Protected Health Information may be subject to further disclosure by the Authorized Recipient and the information will no longer be protected under the federal privacy protection regulations issued by the U.S. Department of Health and Human Services. I understand that I may refuse to sign this authorization and that doing so will not interfere with my treatment at or by the Practice or payment for that treatment. I have read the above and authorize the use or disclosure of the Protected Health Information as stated.

_____ _____

Signature of Patient or Patient's Representative Date

If signed by Patient's Representative, indicate relationship to the Patient: _____

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DC HEALTH Universal Health Certificate

Use this form to report your child's physical health to their school/child care facility. This is required by DC Official Code §38-602. Have a licensed medical professional complete part 2 - 4. Access health insurance programs at https://dchealthlink.com. You may contact the Health Suite Personnel through the main office at your child's school.

Part 1: Child Personal Information | To be completed by parent/guardian.

Child Last Name:	**Child First Name:**	**Date of Birth:**
School or Child Care Facility Name:	**Gender:** ☐ Male ☐ Female ☐ Non-Binary	

Home Address:	**Apt:**	**City:**	**State:**	**ZIP:**

Ethnicity: *(check all that apply)* ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Other ☐ Prefer not to answer

Race: *(check all that apply)* ☐ American Indian/ Alaska Native ☐ Asian ☐ Native Hawaiian/ Pacific Islander ☐ Black/African American ☐ White ☐ Prefer not to answer

Parent/Guardian Name:	**Parent/Guardian Phone:**
Emergency Contact Name:	**Emergency Contact Phone:**

Insurance Type: ☐ Medicaid ☐ Private ☐ None **Insurance Name/ID #:**

Has the child seen a dentist/dental provider within the last year? ☐ Yes ☐ No

I give permission to the signing health examiner/facility to share the health information on this form with my child's school, child care, camp, or appropriate DC Government agency. In addition, I hereby acknowledge and agree that the District, the school, its employees and agents shall be immune from civil liability for acts or omissions under DC Law 17-107, except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct. I understand that this form should be completed and returned to my child's school every year.

Parent/Guardian Signature: _____ **Date:** _____

Part 2: Child's Health History, Exam, and Recommendations | To be completed by licensed health care provider.

Date of Health Exam:	**BP:** ____ /_____	☐ NML ☐ ABNL	**Weight:**	☐ LB ☐ KG	**Height:**	☐ IN ☐ CM	**BMI:**	**BMI Percentile:**

Vision Screening: Left eye: 20/_____ Right eye: 20/_____ ☐ Corrected ☐ Uncorrected ☐ Wears glasses ☐ Referred ☐ Not tested

Hearing Screening: *(check all that apply)* ☐ Pass ☐ Fail ☐ Not tested ☐ Uses Device ☐ Referred

Does the child have any of the following health concerns? *(check all that apply and provide details below)*

- ☐ Asthma
- ☐ Autism
- ☐ Behavioral
- ☐ Cancer
- ☐ Cerebral palsy
- ☐ Developmental
- ☐ Diabetes
- ☐ Failure to thrive
- ☐ Heart failure
- ☐ Kidney failure
- ☐ Language/Speech
- ☐ Obesity
- ☐ Scoliosis
- ☐ Seizures
- ☐ Sickle cell
- ☐ Significant food/medication/environmental allergies that may require emergency medical care. *Details provided below.*
- ☐ Long-term medications, over-the-counter-drugs (OTC) or special care requirements. *Details provided below.*
- ☐ Significant health history, condition, communicable illness, or restrictions. *Details provided below.*
- ☐ **Other:**_____

Provide details. If the child has Rx/treatment, please attach a complete Medication/Medical Treatment Plan form; and if the child was referred, please note. _____

_____

TB Assessment | Positive TST should be referred to Primary Care Physician for evaluation. For questions call T.B. Control at 202-698-4040.

What is the child's risk level for TB?

☐ High → *complete skin test and/or Quantiferon test*

☐ Low

Skin Test Date:			**Quantiferon Test Date:**	
Skin Test Results:	☐ Negative	☐ Positive, CXR Negative	☐ Positive, CXR Positive	☐ Positive, Treated
Quantiferon Results:	☐ Negative	☐ Positive	☐ Positive, Treated	

Additional notes on TB test:

Lead Exposure Risk Screening | All lead levels must be reported to DC Childhood Lead Poisoning Prevention. Call 202-654-6002 or fax 202-535-2607.

ONLY FOR CHILDREN UNDER AGE 6 YEARS *Every child must have 2 lead tests by age 2*	**1st Test Date:**	**1st Result:** ☐ Normal ☐ Abnormal, **Developmental Screening Date:**	**1st Serum/Finger Stick Lead Level:**
	2nd Test Date:	**2nd Result:** ☐ Normal ☐ Abnormal, **Developmental Screening Date:**	**2nd Serum/Finger Stick Lead Level:**

HGB/HCT Test Date:	**HGB/HCT Result:**

Part 3: Immunization Information | To be completed by licensed health care provider.

Child Last Name:	Child First Name:	Date of Birth:

Immunizations	In the boxes below, provide the dates of immunization (MM/DD/YY)						
Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5		
DT (<7 yrs.)/ Td (>7 yrs.)	1	2	3	4	5		
Tdap Booster	1						
Haemophilus influenza Type b (Hib)	1	2	3	4			
Hepatitis B (HepB)	1	2	3	4			
Polio (IPV, OPV)	1	2	3	4			
Measles, Mumps, Rubella (MMR)	1	2					
Measles	1	2					
Mumps	1	2					
Rubella	1	2					
Varicella	1	2	Child had Chicken Pox (month & year): Verified by: _____ (name & title)				
Pneumococcal Conjugate	1	2	3	4			
Hepatitis A (HepA) (Born on or after 01/01/2005)	1	2					
Meningococcal Vaccine	1	2					
Human Papillomavirus (HPV)	1	2	3				
Influenza (Recommended)	1	2	3	4	5	6	7
Rotavirus (Recommended)	1	2	3				
Other	1	2	3	4	5	6	7

☐ The child is **behind on immunizations** and there is a plan in place to get him/her back on schedule. **Next appointment is:** _____

Medical Exemption (if applicable)
I certify that the above child has a valid medical contraindication(s) to being immunized at the time against:

☐ Diphtheria ☐ Tetanus ☐ Pertussis ☐ Hib ☐ HepB ☐ Polio ☐ Measles
☐ Mumps ☐ Rubella ☐ Varicella ☐ Pneumococcal ☐ HepA ☐ Meningococcal ☐ HPV

Is this medical contraindication permanent or temporary? ☐ Permanent ☐ Temporary until: _____ (date)

Alternative Proof of Immunity (if applicable)
I certify that the above child has laboratory evidence of immunity to the following and I've attached a copy of the titer results.

☐ Diphtheria ☐ Tetanus ☐ Pertussis ☐ Hib ☐ HepB ☐ Polio ☐ Measles
☐ Mumps ☐ Rubella ☐ Varicella ☐ Pneumococcal ☐ HepA ☐ Meningococcal ☐ HPV

Part 4: Licensed Health Practitioner's Certifications | To be completed by licensed health care provider.

This child has been appropriately examined and health history reviewed and recorded in accordance with the items specified on this form. At the time of the exam, this child is **in satisfactory health** to participate in all school, camp, or child care activities except as noted on page one. ☐ No ☐ Yes

This child is cleared for **competitive sports.** ☐ N/A ☐ No ☐ Yes ☐ Yes, pending additional clearance from: _____
_____

I hereby certify that I examined this child and the information recorded here was determined as a result of the examination.

Licensed Health Care Provider Office Stamp	Provider Name:	
	Provider Phone:	
	Provider Signature:	Date:

OFFICE USE ONLY | Universal Health Certificate received by School Official and Health Suite Personnel.

School Official Name:	Signature:	Date:
Health Suite Personnel Name:	Signature:	Date: