GARRETT COUNTY HEALTH DEPARTMENT

Partners After School @ Friendsville 2026-2027Application

Child's Name_____ Grade_____

Child's School _____ Date of Birth _____

Race/Ethnicity	Gender	Is Child Eligible for Free or Reduced Meals
❒ American Indian/Alaskan Native ❒ Asian/Pacific Islander ❒ Bi-racial ❒ Black or African-American ❒ Hispanic/Latino ❒ Middle Eastern/North African ❒ White ❒ Race not listed	❒ Male ❒ Female	❒ Yes ❒ No

Partners After School Program does not discriminate on the basis of gender, race, age, color, religious belief, national origin, or disability in providing access to programs.

Street Address _____

City, Town, and Zip Code _____

Mailing Address (If different from Street Address)

_____

Primary Phone _____ Parent/ Guardian E-Mail Address_____

Check the DAYS your child plans to attend the After School program

❒ Mondays ❒ Tuesdays ❒ Wednesdays ❒ Thursdays

Parent / Guardian Names Cell Phone Home Phone Daytime Phone

_____

_____

Emergency Contacts *(List 2 and **state relationship** to child)* Home Phone Cell Phone

_____

_____

List the names of any other persons *(in addition to parent / guardian/ emergency contacts)* authorized to pick up your child

_____

Child's Physician _____ Phone _____

(OFFICE USE ONLY) Tracking # ___ ___ ___ ___
Student Start Date:___/___/___

Child's Dentist _____ Phone _____

Child's Health Insurance_____

Policy Number _____ Date of last tetanus shot *(if known)* _____

Medications **Please list but also note if there are medications that need to be given during the PAS program.*

_____

List all allergies and medical conditions (bee sting, food and medication allergies, seizures, etc.) and care needed if child is exposed to allergen or experiences problems with the condition.

_____

Does your child have any mobility limitations or other handicapping conditions *(vision, hearing, speech / language, emotional / mental / behavioral, physical impairment, etc.)* that will require accommodations to ensure full participation in program activities?

_____

What, if any, specific things would you like for us to work on with your child *(Life-skills, socialization, teamwork, etc.)?* What are your goals for your child in our program?

_____

Please keep After School staff updated regarding your child's special requirements. If there is a change in your child's condition, please contact us so that proper accommodation can be made for your child.

In emergencies requiring immediate medical attention, your child will be taken to the nearest hospital emergency room. Your signature below authorizes After School staff to have your child transported to the nearest hospital or medical facility for treatment.

Parent / guardian permission slips are typically required for field trips. However, After School staff periodically transports students to nearby local areas for educational, cultural enrichment, and recreational activities without a specific permission slip. Some After School activities may also include being photographed and recorded.

Directory information (name, grade, gender) may be provided to after school partners, who provide enrichment activities, which could include: UMD Extension - Garrett County Office, Adventure Sports Institute of Garrett College, Ruth Enlow Library, and/or the Garrett Arts Council, etc.

Please check below if Partners After School, Garrett County Health Department, and other providers (for example: UMD Extension - Garrett County Office, Adventure Sports Institute of Garrett College, and/or the Garrett Arts Council staffs, etc.) may use my child's name, photograph likeness, and/or audio / video recording for the purpose of public awareness, community health education, and/or press releases that may include digital media, such as Facebook, Twitter, and other social media websites.

❒ Yes, I consent to the above media release for my child

❒ No, I do not want my child's media to be used for publicity purposes

I agree to allow my child to participate in Partners After School program.

Signature of Parent / Legal Guardian Date

Printed Name of Parent/Guardian

Partners After School

Parent Consent for Evaluation and Release of Information

We would like your child to participate in the evaluation of the **Partners After School** program. Your child's participation in the evaluation is important to us and will help us to assess the effectiveness of our After School program and to apply for continued funding. *Your child is not required to participate in the evaluation and refusing to be part of the evaluation will not affect your child's participation in the **Partners After School** program.*

- With your permission, staff from the Garrett County Local Management Board (LMB) will work with the **Partners After School** program and the Board of Education to document your child's progress. LMB staff will use the student's 4-Digit Tracking number to link the data sets. Student names will not be on the aggregated Board of Education data reports or on the aggregated After School Attendance reports. Your child's privacy will be protected. Additionally, the Maryland Out-of-School Time Network's (MOST) **Youth Program Quality Assessment** (YQPA) will be used to conduct a program self-assessment and to develop an improvement plan for each site.

The LMB will collect the following information from participating **Partners After School** families:

- ATTENDANCE for the After School Program
- TRACKING INFORMATION – Student's 4-digit tracking number, grade, gender, and race/ethnicity
- PARENT SATISFACTION SURVEYS will be administered on-site each school year
- STUDENT SURVEYS will be administered on-site at various times each school year.
- DIRECTORY INFORMATION – Student's grade, gender, and race/ethnicity, as well as free and reduced meals and special education status (IEP)
- ATTENDANCE at school - for the current school year
- STUDENT HEALTH INFORMATION including but not limited to: height, weight, Body Mass Index, ½ mile walk/run speed, heart rate, blood pressure, and allergies.

By signing below, I confirm that this form has been explained to me and that I understand it. I also give permission for my child to complete the Youth Health Survey administered by the Health Education and Outreach staff from the Garrett County Health Department.

PLEASE CHECK ONE:

❑ I AGREE to let my child participate in the **Partners After School** evaluation and Youth Health Survey

❑ I DO NOT agree to let my child participate in the **Partners After School** evaluation and Youth Health Survey

Child's Name: _____ Grade: _____

Parent/Guardian Signature: _____ Date: _____

Please check below if your family is affected by any of the following:

- ○ Does your child have a parent/guardian who is between the ages of 16 and 24 who is neither working nor in school?

- ○ Does your child have a parent/guardian who is currently, or was previously, incarcerated- including those under criminal justice supervision prior to or following a period of incarceration?

- ○ Has your household had a time in the last 12 months when you could not afford, or did not have access to, enough food?

- ○ Is anyone in your family under the age of 25 and lacks a fixed, regular, and adequate nighttime residence; this includes those living in motels, hotels, camping grounds, emergency or transitional shelters, cars, parks, public, spaces, abandoned buildings, and bus or train stations for who it is not possible to live with their parent, guardian or relative and have no safe alternative living arrangement?

- ○ Is the applicant affected by out of home placement?

  - ❒ Foster Care
  - ❒ Kinship Care
  - ❒ Group/Residential Treatment Care

○ If the applicant has been affected by an adverse childhood experience, please check the box.

Adverse Childhood Experiences:

1. Physical abuse
2. Sexual abuse
3. Verbal abuse
4. Physical neglect
5. Emotional neglect
6. A family member who is depressed or diagnosed with other mental illness
7. A family member who is addicted to alcohol or another substance
8. A family member who is in prison
9. Witnessing a mother being abused
10. Losing a parent to separation, divorce or death
11. Trauma from a natural disaster
12. Trauma from community violence