Department of Human Service Programs
Ellen Semonoff, Assistant City Manager

City of Cambridge
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DHSP Registration Form: Child and Youth Participant Information

Participant Information

First Name: _____ Middle Name: _____

Last Name: _____ Other Name Participant Uses: _____

Date of Birth (mm/dd/yyyy): _____

Please select the gender and race that best represent how the participant identifies. We recognize that the available response options may be limited and that there are identities that are not captured by the options in these questions. By asking these questions, we are taking an initial step to inform our efforts to ensure our recruitment and enrollment processes are equitable.

Gender Identity: Female ☐ Male ☐ Non-binary/Gender non-conforming ☐ Transgender ☐

Prefer to self-describe: _____

Race: Asian/Asian-American ☐ Black/African-American ☐ Hispanic/Latinx ☐ Multi-Racial ☐

Native American/Alaskan ☐ Pacific Islander/Native Hawaiian ☐ White ☐

Prefer to self-describe: _____

Pronouns: _____ Primary Language spoken at home: _____

Other language(s) spoken: _____

Many of our programs accept childcare vouchers from the Massachusetts Department of Early Education and Care. Please check this box if you have a childcare voucher. ☐

Description of Participant

Eye Color: Blue ☐ Brown ☐ Green ☐ Hazel ☐ Grey ☐

Hair Color: Black ☐ Blonde ☐ Brown ☐ Red ☐

Height (feet, inches): _____ Weight (pounds): _____

Identifying marks: _____

Additional Emergency Contact and Authorized Pick Up 1

First Name: _____ Last Name: _____

Relationship to child (check one): Foster Parent ☐ Friend ☐ God-Parent ☐ Grandparent ☐ Other

Family Member ☐ Parent ☐ Sibling ☐ Step-Parent ☐ Other _____

Is authorized to pick up? Yes ☐ No ☐ Is emergency contact? Yes ☐ No ☐

Phone Number Type: Cell ☐ Home ☐ Work ☐ Phone: _____

Additional Emergency Contact and Authorized Pick Up 2

First Name: _____ Last Name: _____

Relationship to child (check one): Foster Parent ☐ Friend ☐ God-Parent ☐ Grandparent ☐ Other

Family Member ☐ Parent ☐ Sibling ☐ Step-Parent ☐ Other _____

Is authorized to pick up? Yes ☐ No ☐ Is emergency contact? Yes ☐ No ☐

Phone Number Type: Cell ☐ Home ☐ Work ☐ Phone: _____

Medical and Health Information

Please note that there is no nurse on-site during program hours. Children are not able to attend program without the "Medication Consent" form and "Individual Health Care Plan" form signed by a parent/caregiver/guardian and the child's medical provider. Please contact the Program Director for copies of all forms. Families must also provide any required medication, such as EpiPens or Inhalers, for the child to have in program.

Physician Name: _____ Physician Phone: _____

Health Insurance Company: _____ Policy Number: _____

Does the participant have any:

Allergies? Yes ☐ No ☐ Food sensitivities? Yes ☐ No ☐

Medical restrictions? Yes ☐ No ☐ Other special considerations or needs? Yes ☐ No ☐

Please describe any allergies, medical conditions, or other considerations below.

_____

Does the participant: Carry an EpiPen? Yes ☐ No ☐ Carry an inhaler? Yes ☐ No ☐

Require any other medication? Yes ☐ No ☐

If the participant requires any medication, please check here to give consent for the program to provide medication. ☐

If the participant requires medication, please specify: _____

School Information

School Year: _____ Grade: _____ School Name: _____

Additional Information for Afterschool, Community School, and Youth Center Programs

Classroom or Homeroom Teacher Name: _____

Does this child receive free or reduced lunch? Yes ☐ No ☐

Inclusion Policy: Department of Human Service Programs (DHSP) welcomes individuals with disabilities in our Out of School Time (OST) Programs. DHSP will provide reasonable accommodations to individuals with disabilities who meet the basic eligibility requirements of the OST Programs or who, with the provision of reasonable accommodations, will be able to meet the basic eligibility requirements.

Does the child have a 504? Yes ☐ No ☐

Does the child have an IEP (Individualized Education Plan)? Yes ☐ No ☐

Participant Phone: _____ Participant Email: _____

Arrival and Dismissal Plan

Will this child arrive at the program by a school bus? Yes ☐ No ☐

If this child takes a school bus to program, write the name of the bus here: _____

If your child is registering for the Preteen/Middle School programs, please indicate which days of the week they will attend.

Days of the Week I expect my child to attend	Monday ☐	Tuesday ☐	Wednesday ☐	Thursday ☐	Friday ☐
Expected Arrival Time					
Expected Departure Time					

Children who are 9 years or older are allowed to self-dismiss. If your child is 9 years or older, do you give permission for them to self-dismiss? Yes ☐ No ☐

Permissions Required for All Programs

I acknowledge that by selecting "Yes" below I am giving my permission to the Department of Human Service Programs for each of the following.

I understand the program staff are trained in First Aid/CPR and I authorize them to give my child First Aid/CPR when appropriate and to apply first aid ointment to minor scrapes and abrasions. Yes ☐ No ☐

In case of emergency, I authorize staff to have my child transported to the nearest hospital to receive necessary medical treatment. Yes ☐ No ☐

I authorize program staff to photograph my child and use it for identification purposes within the program. Yes ☐ No ☐

I authorize the City of Cambridge to use, reproduce, and/or publish photographs or video of my child. I understand that these images may be used in print, online, or in video-based marketing materials as well as other City publications. Yes ☐ No ☐

I authorize my child to participate in off-site activities. This includes visits to nearby parks, public libraries, or walks around the neighborhood. Yes ☐ No ☐

Additional Permissions Required for Preschool

I give permission for the topical application of sunscreen, insect repellant, and/or Vaseline by staff. Yes ☐ No ☐

I give permission for my child to participate in daily tooth brushing in the classroom. I understand that the program will provide toothbrushes and toothpaste. Yes ☐ No ☐

I give permission for my child to participate in a dental screening. Yes ☐ No ☐

I give permission for my child to participate in a vision screening. Yes ☐ No ☐

I give permission for my child to participate in a hearing screening. Yes ☐ No ☐

Additional Permissions Required for Afterschool, Community Schools, and Youth Center Programs

My child's immunization records and evidence of a lead screening test are on file with my child's school. Yes ☐ No ☐

I hereby authorize the Department of Human Service Programs (DHSP) staff to visit my child's school day classroom/program and to discuss with relevant personnel (teachers, specialists, school nurse, therapists, medical providers, and other caregivers) any pertinent information regarding my child in the context of evaluating and supporting their participation in DHSP's out of school time (OST) programs. Yes ☐ No ☐

I hereby authorize my child's school/program to release my child's records including their Individualized Education Plan (IEP), Behavioral Intervention Plan, and/or Section 504 Plan. DHSP will not disclose the content of any such records to any other party without my written consent, except as DHSP may be required by law to do so. All records will be used for the purpose of evaluating and supporting my child's participation in DHSP's OST programs. Yes ☐ No ☐

Parent/Guardian Signature: _____ Date: _____

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DHSP Registration Form: Household Information

Primary Guardian

First Name: _____ Last Name: _____

Is primary emergency contact? Yes ☐ No ☐ Is emergency contact? Yes ☐ No ☐

Is authorized to pick up? Yes ☐ No ☐

Relationship to participant (check one): Foster Parent ☐ Friend ☐ God-Parent ☐ Grandparent ☐

Other Family Member ☐ Parent ☐ Self ☐ Sibling ☐ Step-Parent ☐ Other (specify) _____

Home Address: _____ City: _____

State: _____ Zip Code: _____

Primary Phone Number: _____ Phone Type (check one): Cell ☐ Home ☐ Work ☐

Other Phone Number: _____ Phone Type (check one): Cell ☐ Home ☐ Work ☐

Email Address: _____

Email Type (check one): Professional ☐ Personal ☐ Other ☐

Other Guardian

First Name: _____ Last Name: _____

Is primary emergency contact? Yes ☐ No ☐ Is emergency contact? Yes ☐ No ☐

Is authorized to pick up? Yes ☐ No ☐

Relationship to participant (check one): Foster Parent ☐ Friend ☐ God-Parent ☐ Grandparent ☐

Other Family Member ☐ Parent ☐ Self ☐ Sibling ☐ Step-Parent ☐ Other (specify) _____

Home Address: _____ City: _____

State: _____ Zip Code: _____

Phone Number: _____ Phone Number Type (circle one): Cell ☐ Home ☐ Work ☐

Other Phone Number: _____ Phone Type (check one): Cell ☐ Home ☐ Work ☐

Email Address: _____

Email Type (check one): Professional ☐ Personal ☐ Other ☐

Please specify any communication accommodations needed by a parent/guardian.

Name: Need TTY (Text to Telephone): Yes ☐ No ☐ Need Interpreter: Yes ☐ No ☐ Language Spoken:	Name: Need TTY (Text to Telephone): Yes ☐ No ☐ Need Interpreter: Yes ☐ No ☐ Language Spoken:

Household Financial Information

The City of Cambridge Department of Human Service Programs is committed to ensuring access to programs for all families. We provide financial assistance and scholarships to all our programs. In order to help us understand how to best financially support your household, please answer the two questions below.

Please look at the table below and select the range that includes your family's annual, or yearly, income. This would include the income of all adults living in the same household.

Less than $25,500	
$25,500-$50,999	
$51,000-$66,299	
$66,300-$81,599	
$81,600-$101,999	
$102,000-$122,399	
$122,400-$152,999	
$153,000-$203,999	
$204,000-$225,000	
More than $225,000	

Does your household currently receive any of the following? (check all that apply)

SNAP	No ☐ Yes ☐	WIC	No ☐ Yes ☐
Fuel Assistance	No ☐ Yes ☐	Housing Voucher (e.g., Section 8)	No ☐ Yes ☐
Medicare	No ☐ Yes ☐	Unemployment	No ☐ Yes ☐
TANF	No ☐ Yes ☐	SSI/SSDI	No ☐ Yes ☐
VA Benefits	No ☐ Yes ☐	Other form of government subsidy/assistance	No ☐ Yes ☐