



**YES
Brentwood Schools
Advantage After School Program**

Program Description

The YES Brentwood Advantage After School Program is a high interest, creative, interactive, safe place for 6th, 7th and 8th grade students to gather after school. The program will operate daily Monday through Friday from 2:30 pm – 5:30 pm. This program will develop healthy minds, healthy bodies and healthy students. Program activities will include academics, nutritional, educational health activities and physical education.

Program Objectives:

- I. A supervised and safe after school program.
- II. A designated homework period Monday through Thursday.
- III. Tutoring and academic assistance.
- IV. Daily activities will be based on physical, health and nutrition education and healthy choices.

Activities may include:

- Field trips to local museums, libraries, cultural activities, career sites, recreation and entertainment, community service sites, etc.
- Dance instructional programs
- Sports
- Creative arts workshops

Guest speaker for appropriate, relevant topics



YES

Brentwood Schools

Advantage After School Program

Process:

Youth will arrive at the program and sign in. The youth will have snack and then begin the homework period. Youth will sign up for the activities they are interested in prior to the day of the activity. All youth will be encouraged to sample different options to decide what they like to do and are interested in. At the end of the day Parent / Guardian must pick their child up and sign out on the sign-in sheet.

Activities

Time will be provided for active play, games, crafts, reading time/distance learning (where available), physical activity, snack time and other organized activities. All activities will be designed to maintain 6 feet of distance between participants.

Safety and Security

- Children attending the YES program will receive a daily health check by the YES staff. Any child that has a fever and/or demonstrates any sign of illness will be separated until the child is picked up.
- Masking is optional but encouraged.
- Parents/Guardians must check the child out of the program each day. Parents that are ill must not enter the program, nor can the children attend during the illness.
- Student to staff ratio will be 15:1, children will be maintained in small groups. Throughout the day the children will remain in small groups of 15 and will practice social distancing as much as practical during activities.
- Visitors to the program are prohibited in order to limit the possibility of exposure to illness.
- Children will be required to wash their hands frequently and to practice good hygiene at all time.
- Children are expected to be showered / bathed daily, and in clean clothing.

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Brentwood Schools
Advantage After School Program
Parental Agreement Form

Parents / Guardians Responsibilities:

1. Parent must sign all registration forms.
2. Parents/Guardians must sign the child out of the program each day. Parents that are ill must not enter the program, nor can the children attend during the illness.
3. Children are expected to be showered / bathed daily, and in clean clothing.
4. Parents must provide a personal mask and hand sanitizer each day.
5. Masking is optional but encouraged.
6. Parents must keep their child home if they are showing signs of illness. Children attending the YES program will receive a daily health check by the YES staff. Any child that has a fever and/or demonstrates any sign of illness will be separated from the program until they are able to be picked up.
7. Parents must ensure that the child has homework and/or study materials for the homework period.
8. Parents will provide necessary equipment for specific activities such as sneakers for various sports, etc.
9. Parents must ensure that their child wear YES T-Shirts for specific field trips (No Exceptions). If your child loses his/her t-shirt, a new one will be issued with a \$10 charge.
10. Parents must ensure that their child attends the program daily and remains in program until 5:15pm. Attendance will be taken every day. Due to the popularity of the YES Brentwood ASAP program, there is usually a waiting list. If your child's attendance is sporadic, he/she will face the possibility of being dropped from the program.
11. If disciplinary issues arise with your child, you will be contacted by YES ASAP staff. With the cooperation of the parent and the YES ASAP staff, a positive resolution to the problem should be reached. Brentwood Middle School Code of Conduct will be used if disciplinary action is warranted.
12. A parent or guardian will sign out the child prior to his/her departure from the program. At no time will a child be allowed to walk or ride their bicycle home. They will only be released to parent/guardian or designee. No exceptions.

Parent / Guardian Signature _____

Date _____

Youth Enrichment Services Brentwood Schools Advantage After School Program Registration

Name of child _____ Date of Birth _____

School _____ Grade _____ School ID # _____

Race / Ethnicity:

Check all that apply

_____ Black

_____ White

_____ Native American/
Alaska Native

_____ Native Hawaiian/
Pacific Islander

_____ Hispanic

_____ Asian

_____ Other

Gender:

_____ Male

_____ Female

Primary Language spoken at home: English _____ Spanish _____ Other: _____

Parent / Guardian Name (print) _____

Address _____

Home # _____ Mobile # _____ Work # _____

Email: _____

Are you the head of the household? Yes _____ No _____

If not, who is the head of the household _____ Relationship _____

Optional

For purposes of securing additional funding for afterschool programs, we ask you to complete this section. All information is kept confidential and only used by YES statistically.

Number of People in Household _____

Does your family receive or eligible to receive?

_____ Free Lunch

_____ Reduced Lunch

_____ Public Assistance

_____ Food Stamps

_____ Social Security Disability

_____ Housing Subsidies

The total income level that most accurately corresponds to my household is: (Check only one)

Less than \$25,000	25,000 – 29,999	30,000-34,999	35,000 – 39,999	40,000 – 44,999
45,000 – 49,999	50,000 – 54,999	55,000 – 59,999	60,000-64,999	65,000 – 69,999
70,000 – 79,999	80,000 – 89,999	90,000 – 99,999	100,000- 109,999	110,000 or above

Parent / Guardian Signature _____ Date _____

YES
Youth Enrichment Services
YES After School Program
Health Form

Name _____ Date of Birth _____

Address _____

Phone Number _____ Mobile _____

Emergency Contact _____ Phone Number _____

School _____ Grade _____

My child is in good health and can fully participate in this program. Yes _____. No _____

**** If you write Yes to any of the following conditions or allergies, you must complete the Individual Health Care Plan.**

Health History (write Yes to each item that applies)

_____ Excessive Bleeding	_____ Mononucleosis / Epstein Barr
_____ Hypertension	_____ Ear Infections
_____ Diabetes	_____ Heart Defect / Disease
_____ Convulsions / or history of epilepsy	
_____ Other (specify) _____	

Allergies:

_____ Asthma	_____ Insect Bites	_____ Hand Sanitizer
_____ Hay Fever	_____ Penicillin	
_____ Poison Ivy	_____ Other Drugs	
_____ Other (specify) _____		

Food Allergies _____

Please list any medication your child is taking: _____

My child is in good health and I hereby give permission for my child to participate in the YES After School Program. In signing this application, I hereby certify that the above information is correct. In case of medical emergency, I understand that every effort will be made to contact parent or guardian. In the event that I cannot be reached, I hereby give permission for the YES Staff to give consent for necessary medical treatment, to hospitalize, and to order injection, anesthesia or surgery for my child,
 _____ (name).

Parent / Guardian Name (print) _____

Parent / Guardian Signature _____ **Date** _____

Witness Name (print) _____

Witness Signature _____ **Date** _____

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Youth Enrichment Services
YES After School Program
Individual Health Care Plan for a Child
With Special Health Care Needs
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Name _____ Date of Birth _____

Name of Child's Health Care Provider:	<input type="checkbox"/> Physician <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Nurse Practitioner
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What is your child's health condition / allergy? _____

What preventative measures should be taken so that your child's health condition / allergy is not triggered? _____

Are there any symptoms that indicate that your child's health condition / allergy has been triggered or is about to be triggered?

What typically triggers your child's health condition / allergy? _____

What is your child's reaction once the health condition / allergy has been triggered? _____

What steps should staff take once the health condition / allergy has been triggered? _____

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Youth Enrichment Services
YES After School Program
Individual Health Care Plan for a Child
With Special Health Care Needs

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Does your child require medications during program hours to treat the health condition / allergy?

No _____ Yes (List) _____

****If yes, a Written Medication Consent form must be completed**

If medications are required during program hours, does your child have permission to self carry?

No _____ Yes _____

If no, then the YES program must be provided with the medication to store. The medication must be in its original packaging with package instructions. The medication must not be expired or set to expire at any point during the school year. Your child will not be able to attend the program until the medication has been provided.

Please list any other medications that your child takes to treat the health condition / allergy during non program hours. _____

Please describe any other additional training, procedures or competencies that staff will need to carry out the health care plan.

I _____, parent / guardian of _____, have reviewed the above plan and provided the necessary training to the following YES program staff.

Name & Credentials	Name & Credentials	Name & Credentials

Parent / Guardian Signature _____ Date _____

This plan was developed in close collaboration with the child's parent / guardian. The caregivers identified to provide all treatments and administer medication to the child listed in the specialized individual health care plan are familiar with the child care regulations and have received any additional training needed and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

Program Name: Youth Enrichment Services Program Location: _____

Program License/ Registration Number _____ Program Phone Number: _____

Site Coordinator Name (Print) _____

Site Coordinator Signature _____ Date _____

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
INDIVIDUAL ALLERGY AND ANAPHYLAXIS EMERGENCY PLAN

Instructions:

- This form is to be completed for any child with a known allergy.
- The child care program must work with the parent(s)/guardian(s) and the child's health care provider to develop written instructions outlining what the child is allergic to and the prevention strategies and steps that must be taken if the child is exposed to a known allergen or is showing symptoms of exposure.
- This plan must be reviewed upon admission, annually thereafter, and anytime there are staff or volunteer changes, and/or anytime information regarding the child's allergy or treatment changes. This document must be attached to the child's Individual Health Care Plan.
- Add additional sheets if additional documentation or instruction is necessary.

Child's Name: _____ Date of Plan: / /
 Date of Birth: _____ Current Weight: _____ lbs.
 Asthma: ☐ Yes (higher risk for reaction) ☐ No

My child is reactive to the following allergens:

Allergen:	Type of Exposure: (i.e., air/skin contact/ingestion, etc.):	Symptoms include but are not limited to: (check all that apply)
		<input type="checkbox"/> Shortness of breath, wheezing, or coughing <input type="checkbox"/> Pale or bluish skin, faintness, weak pulse, dizziness <input type="checkbox"/> Tight or hoarse throat, trouble breathing or swallowing <input type="checkbox"/> Significant swelling of the tongue or lips <input type="checkbox"/> Many hives over the body, widespread redness <input type="checkbox"/> Vomiting, diarrhea <input type="checkbox"/> Behavioral changes and inconsolable crying <input type="checkbox"/> Other (specify)
		<input type="checkbox"/> Shortness of breath, wheezing, or coughing <input type="checkbox"/> Pale or bluish skin, faintness, weak pulse, dizziness <input type="checkbox"/> Tight or hoarse throat, trouble breathing or swallowing <input type="checkbox"/> Significant swelling of the tongue or lips <input type="checkbox"/> Many hives over the body, widespread redness <input type="checkbox"/> Vomiting, diarrhea <input type="checkbox"/> Behavioral changes and inconsolable crying <input type="checkbox"/> Other (specify)
		<input type="checkbox"/> Shortness of breath, wheezing, or coughing <input type="checkbox"/> Pale or bluish skin, faintness, weak pulse, dizziness <input type="checkbox"/> Tight or hoarse throat, trouble breathing or swallowing <input type="checkbox"/> Significant swelling of the tongue or lips <input type="checkbox"/> Many hives over the body, widespread redness <input type="checkbox"/> Vomiting, diarrhea <input type="checkbox"/> Behavioral changes and inconsolable crying <input type="checkbox"/> Other (specify)

If my child was **LIKELY** exposed to an allergen, for **ANY** symptoms:

☐ give epinephrine immediately

If my child was **DEFINITELY** exposed to an allergen, even if no symptoms are present:

☐ give epinephrine immediately

Date of Plan: / /

THE FOLLOWING STEPS WILL BE TAKEN IF THE CHILD EXHIBITS SYMPTOMS including, but not limited to:

- **Inject epinephrine immediately and note the time when the first dose is given.**
- **Call 911/local rescue squad** (Advise 911 the child is in anaphylaxis and may need epinephrine when emergency responders arrive).
- Lay the person flat, raise legs, and keep warm. If breathing is difficult or the child is vomiting, allow them to sit up or lie on their side.
- If symptoms do not improve, or symptoms return, an additional dose of epinephrine can be given in consultation with 911/emergency medical technicians.
- Alert the child's parents/guardians and emergency contacts.
- After the needs of the child and all others in care have been met, immediately notify the office.

MEDICATION/DOSES

- Epinephrine brand or generic:
- Epinephrine dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

ADMINISTRATION AND SAFETY INFORMATION FOR EPINEPHRINE AUTO-INJECTORS

When administering an epinephrine auto-injector follow these guidelines:

- Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than the mid-outer thigh. If a staff member is accidentally injected, they should seek medical attention at the nearest emergency room.
- If administering an auto-injector to a young child, hold their leg firmly in place before and during injection to prevent injuries.
- Epinephrine can be injected through clothing if needed.
- Call 911 immediately after injection.

STORAGE OF EPINEPHRINE AUTO-INJECTORS

- All medication will be kept in its original labeled container.
- Medication must be kept in a clean area that is inaccessible to children.
- All staff must have an awareness of where the child's medication is stored.
- Note any medications, such as epinephrine auto-injectors, that may be stored in a different area.
- Explain here where medication will be stored:

MAT/EMAT CERTIFIED PROGRAMS ONLY

Only staff listed in the program's Health Care Plan as medication administrant(s) can administer the following medications. Staff must be at least 18 years old and have first aid and CPR certificates that cover all ages of children in care.

- Antihistamine brand or generic:
- Antihistamine dose:
- Other (e.g., inhaler-bronchodilator if wheezing):

***Note: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

STORAGE OF INHALERS, ANTIHISTAMINES, BRONCHODILATOR

All medication will be kept in its original labeled container. Medication must be kept in a clean area that is inaccessible to children. All staff must have an awareness of where the child's medication is stored. Explain where medication will be stored. Note any medications, such as asthma inhalers, that may be stored in a different area.

Explain here:

STRATEGIES TO REDUCE THE RISK OF EXPOSURE TO ALLERGIC TRIGGERS

The following strategies will be taken by the child care program to minimize the risk of exposure to any allergens while the above-named child is in care (add additional sheets if needed):

Document plan here:

EMERGENCY CONTACTS – CALL 911

Ambulance: () -	
Child's Health Care Provider:	Phone #: () -
Parent/Guardian:	Phone #: () -

CHILD'S EMERGENCY CONTACTS

Name/Relationship:	Phone#: () -
Name/Relationship:	Phone#: () -
Name/Relationship:	Phone#: () -

Parent/Guardian Authorization Signature:	Date: / /
Physician/HCP Authorization Signature:	Date: / /
Program Authorization Signature:	Date: / /



ACTIVITY PERMISSION AUTHORIZATION

I, _____ parent/guardian of
 Parent / Guardian Name
 _____ hereby give
 Child's Name

permission for my son/daughter to participate in any field trips or activities associated with the YES After School Program. I am fully aware that some of these activities will necessitate transporting my child to another location by either van or bus. My child is in good physical health and is able to engage in full participation. I release YES of any responsibility for any injury, which may result from such participation.

Parent / Guardian Signature _____ *Date* _____

PICTURE / MEDIA PERMISSION AUTHORIZATION

I _____
 parent/guardian of _____

hereby give permission for my son/daughter's picture to be displayed in all publications, media and press related to Youth Enrichment Services. The pictures will be used for display, promotional, press coverage and other related purposes.

Parent / Guardian Signature _____ *Date* _____

REPLACEMENT T-SHIRT FEE

I, _____ parent/guardian of _____ understand that
 Parent / Guardian Name Child's Name

my child will be given one free t-shirt prior to the first field trip. That T-shirt that must be worn for each and every field trip that you child attends. Your child will not be allowed on the field trip if they do not have their shirt. If the shirt is lost or destroyed, a new replacement shirt will cost \$10.00 each. I agree to pay this fee immediately upon pick-up or prior to dropping the child off the next day.

Parent / Guardian Signature _____ *Date* _____

LATE PICK-UP FEE

I understand that there will be a \$5 fee assessed for each 15 minute increment in cases of late pickup. I agree to pay this fee immediately upon pick-up or prior to dropping the child off the next day.

Parent / Guardian Signature _____ *Date* _____

YES Brentwood After-School Program Parental Release Form

Child's Name _____ Date of Birth _____

Parent / Guardian Name (print) _____

Address _____

Home # _____ Mobile # _____ Work # _____

Email: _____

Emergency Contact _____ Relationship to Child _____

Address _____

Home # _____ Mobile # _____ Work # _____

Authorized to pick up child? _____ Yes _____ No

Emergency Contact #2 _____ Relationship to Child _____

Address _____

Home # _____ Mobile # _____ Work # _____

Authorized to pick up child? _____ Yes _____ No

Please list any other adults that you give permission to pick up your child:

1. _____ Relationship: _____ Phone: () _____

2. _____ Relationship: _____ Phone: () _____

3. _____ Relationship: _____ Phone: () _____

Does your child have permission to go home on the late bus in emergency situations? _____
Yes No

Does your child have permission to walk home? _____ Yes _____ No

If yes, are there any restrictions on when your child can walk home? _____

**** Photo ID will be required for pickup.**

**** Anyone else attempting to pick up your child will be denied without your written permission.**

Parent / Guardian Name (print) _____

Parent / Guardian Signature _____ Date _____