



Welcome to the Common Place Scholars After-School Program!

The Common Place strives to provide quality programming for the Southwest Philadelphia Community.

The Common Place Scholars after-school program is a faith based program to provide educational support and academic enrichment to the children of Southwest Philadelphia. This programming focuses on the virtual and performing arts and addition to homework assistance and tutoring.

In order for your child to participate in the after-school program, **you must first complete this application packet accompanied by a physical with a statement from doctor attesting to no known contact or exposure to COVID 19 or provide negative testing results for child with doctor's signature. Then you can provide a \$65 registration fee to save your space. We realize your time is precious; however, all information is necessary and required in order to provide safe, low cost, high quality programming for your child.** The above must happen before your child may participate in our program.

If you have questions or concerns, please feel free to call or email Huan Baum, Program Director at the information listed below. We are here to assist you and look forward to serving you. Thank you and welcome to the Common Place Scholars After-School Program!

**The Common Place After-School Program
5736 Chester Ave
Philadelphia, PA 19143
Telephone (267) 275-8238 ext. 303
Email: programdirector@thecommonplacephilly.org**

The Common Place is an equal opportunity provider. We do not discriminate against on the basis of race, religion or gender.

Date Admitted _____

Date Application Received _____
Registration Received Yes No
Date Registration Received _____

The Common Place Scholars After-School Registration Packet

The Common Place Enrollment Application

Programs of Interest (Check all that apply):

- _____ Visual Arts _____ Drawing _____ Photography
- _____ Painting _____ Dance _____ Computer
- _____ Culinary Arts _____ Knitting _____ HW help
- _____ Sports _____ Music _____ Other

Child's Name: _____

Date of Birth: _____

School Name: _____

Grade: _____

Gender: Male Female

Home Address: _____

Zip: _____

Contact Number: _____ **E-mail address:** _____

Pls List any medications, special needs, or allergies: _____

Caregiver's Name: _____ **Relationship to Child:** _____

Caregiver's Alternate number: _____

Caregiver 2 Contact number: _____

Caregiver 2 Alternate number: _____

How did you hear about us? _____

Child's Name _____

Photograph Release Authorization on behalf of the Common Place

_____ **YES**, I do give permission to have my child appear in any media coverage (t.v., newspaper articles, photographs) on behalf of The Common Place.

_____ **NO**, I do not give permission to have my child appear in any media coverage (t.v., newspaper articles, photographs) on behalf of The Common Place.

Discharge Plan

_____ **YES**, I give my child permission to leave the Common Place on his/her own without being accompanied by an adult. I will not hold the program responsible for the safety and welfare of my child as a result. I understand that my child will be dismissed from the after-school program daily at **6 PM** unless otherwise discussed and agreed to with program staff.

_____ **NO**, I do not give my child permission to leave the after school program.

If you have selected “no” please complete the following:

Who can pick up your child? **Person MUST be over 18 and have ID when arriving.**

Pick-up Person’s Name: 1. _____

Relationship to Child: 1. _____

Address: 1. _____

Phone: 1. _____ 2. _____

Pick-up Person’s Name: 2. _____

Relationship to Child: 2. _____

Address: 2. _____

Phone: 1. _____ 2. _____

Pick-up Person’s Name: 3. _____

Relationship to Child: 3. _____

Address: 3. _____

Phone: 1. _____ 2. _____

Your child will not be released to anyone whom is not listed here unless arranged in advance with program staff. Your child must be picked up promptly at the time the program is scheduled to end. In the event no one can be reached please give a place where your child may be dropped off.

In Case no one is available Person’s Name: _____

Address: _____

Phone: 1. _____

Common Place Parents'/Guardians' Agreement

1. I am enrolling _____ in the Common Place Scholars After-School Program.
2. I understand there is a \$65 registration fee.
3. I understand there is a \$65 (5 day) weekly tuition fee or \$33 (3 day) weekly tuition which is due every Friday by 6 PM.
4. I understand that the Common Place Scholars will be providing after school care from the hours of 3 PM – 6PM Monday thru Friday. I understand TCPS will transport my child from school to the after school program facility. In addition, I understand TCPS will provide snacks for my child, there will be homework assistance provided by staff members, and there will be specialist activities during this time.
5. I understand TCPS may provide extra full or half day care to participants based on the school calendar(s), the availability of staff, and the number of participants signed up for the day, which is included in tuition. During these days participants will be provided a mid-morning snack, lunch, and afternoon snack.
6. I have been made aware of the specific program my child will be participating in, the hours and that the program follows the School District of Philadelphia's and Cornerstone Christian Academy's calendar for school closings.
7. I understand that my child will not be dismissed from the program without being picked up by a parent or designated adult or without given permission for him/her to walk home unescorted. In addition there will be a ***ten minute*** grace period and then ***\$10 fee will be added every 5 mins for any late pick-ups.***
8. I understand that disrespect, fighting, physical and verbal aggression will not be tolerated in this program. In accordance with the Parent Handbook disciplinary procedures, I understand that my child could lose their scholarship and may be discharged immediately for such actions.
9. I understand that if a medical emergency arises, program staff will attempt to contact parents or the emergency contact that I have indicated. It is the parent's responsibility to notify the after-school staff if this information changes. If immediate medical attention is necessary, an ambulance or emergency vehicle may take my child to the hospital of their choice. In cases of illness, I understand that my child may not be permitted to attend the program. If staff feels that a child has a contagious disease, he/she may not return to the program without a doctor's note.
10. I understand that I will adhere to the COVID 19 guidelines set forth by this program. I will provide truthful and accurate information when deemed necessary for the safety of the overall program. I understand that my child may be denied entry/ reentry of program if guidelines have not been followed.
11. ***In order for my child to be considered for this program I understand that I must complete all enrollment paperwork including, physical forms, signing parent handbook, and COVID 19 addendum PRIOR to my child's acceptance to the program.***
12. I understand that the Common Place Scholars after-school program is a faith-based (Christian) program.
13. **I have received complete written program information (parent handbook) at the time of enrollment (PA Code 3270.121, 3280.121, 3290.121)**
14. **I agree to update the emergency contact and parental agreement when changes occur or every 6 months at a minimum. (PA Code 3270.124, 3280.124., 3290.124)**

I have read and agree to adhere to the above stated policies and procedures and give my child permission to participate fully in the Common Place Scholars After-School Program.

Signature of Parent/Guardian _____ Date _____

Signature of TCPS Director _____ Date _____

Date Admitted _____

Date Withdrew _____

6 Month Parental Review

Parent signature

date

Authorization Consent for Release of information

I hereby give consent/authorization to the Common Place to obtain school records for

_____ for the purpose of data collection for service planning.

(Print Participant's Name)

Please release the following information:

Check all that apply:

_____ *IEP/504 Plans* _____ *Academic Progress* _____ *Grades* _____ *Standardized Test Scores*

All of the information I hereby authorize to be obtained will be held strictly confidential by the Common Place and will not be released without the written consent of the person/agency who authorized the information or agency who maintains responsibility for its content.

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time.

Print Name of Parent or Guardian

Signature of Parent or Guardian

Relationship to Participant

Date

6 month update.	Date _____
_____	_____

Emergency Contact/Parental Consent Form

Child's Name	Date of Birth
Home Address	City/State/Zip
Mother's Name/Legal Guardian	Home Phone Number
Home Address/City/State/Zip	Cell Phone Number
Business Name	Business Phone Number
Business Address	City/State/Zip
Father's Name/Legal Guardian	Home Phone Number
Home Address/City/State/Zip	Cell Phone Number
Business Name	Business Phone Number
Business Address	City/State/Zip
Emergency Contact Person(s)	
Name Address/City/State/Zip	Phone Number
Person(s) To Whom Child May Be Released	
Name Address/City/State/Zip	Phone Number
Name of Child's Physician/Medical Care Provider	Phone Number
Address	City/State/Zip
Special Disabilities (if any)	Allergies (including medication reaction)
Medical or Dietary Information Necessary in an Emergency Situation	Medication, Special Conditions
Health Insurance Coverage for Child or Medical Assistance Benefits	Policy (number required)
Additional Information on Special Needs of Child	

Parent's Signature is required for each item below to indicate parental consent:

Obtaining Medical Care x _____ Admin. of Minor First Aid Procedures x _____
 Transportation by the Facility x _____ Walks and Trips x _____

Parent or Guardian Signature _____ **Date** _____

Parent or Guardian Signature _____ **Date** _____

**RELEASE AND WAIVER FOR PARTICIPATION IN
SPORTS AND RECREATIONAL ACTIVITIES**

Name of Minor/Participant: _____

Address: _____

Print Parent/Guardian Name: _____

Telephone Number(s) where parent/guardian can be reached in the event of an emergency:

***Warning: By signing this document you will waive legal rights, including the right to sue.
Please read carefully!***

Assumption of risk:

The undersigned understands that participation in sports and recreational activities with the Common Place scholars after-school program involves inherent risks including the risk of property damage, personal injury or death, which might result from the use of equipment or facilities, from the activity itself, from the acts of others, or from the unavailability of emergency medical care. On behalf of the above named minor and on my own behalf, I freely accept and fully assume all such risks, dangers, and hazards and the possibility of personal injury, death, property damage or loss, resulting there from.

Release of Liability, Waiver of Claims and Indemnity Agreement.

In consideration of the Common Place allowing the minor to participate in sports and recreational activities, I make the following agreements, to the fullest extent permitted by law:

1. To waive any and all claims that minor or I may have in future against The Common Place, its directors, administrators, employees, agents, volunteers and independent contractors (all of whom are herein after collectively referred to as "the Releases"), including but not limited to property damage, injury, or death of the minor.
2. To release the Releases from any and all liability for any loss, damage, injury or expense that minor or I may suffer, as a result of participation in any sport or recreational activity with the Common Place's after-school program, due to any cause whatsoever including negligence, breach of contract, or breach of any statutory or other duty of care, on the part of the Releases, including, for instance, failure to provide supervision or proper instructions, the use and adjustment of machinery and anything related to use of the services, facilities or premises involved in the program.
3. To indemnify, hold harmless and defend the Releases from any and all liability for any damage to the property of, or personal injury or death to any third party, resulting in any way from minor's conduct and participation in sports or recreational activities with the Common Place.

Definitions.

I understand and agree that the terms such as “participate” and “sports and recreational activities” referred to in this Agreement includes all exercises and physical movements of any nature while I am participating in the Common Place’s programs.

Emergency Treatment Consent.

The undersigned hereby consents to minor’s medical treatment in a medical emergency where the undersigned is unable to consent to such treatment.

Insurance.

The undersigned understands that the Common Place does not carry medical insurance for minor’s participation in sports and recreational activities. The minor is encouraged to have a physical examination and to purchase medical insurance prior to any and all participation.

I am the parent and/or legal guardian of the above named minor. I have read and understand that the agreement involves surrendering valuable legal rights of the minor and myself. In entering this agreement, I am not relying upon any oral or written representations or statements made by the Common Place or the Releases other than what is set forth in this agreement.

I agree that minor and I are bound by all terms of this agreement. I also give my consent to the minor’s participation in sports and recreational activities.

Signature of Parent or Guardian for participant under 18 years:

Witness Signature:

Date:

This agreement must be completed in full, signed, dated and witnessed before the minor may participate in sports and recreational activities.

First Aid and Emergency Medical Care Consent Form

Child's Name: _____ Date of Birth: _____

I authorize staff in the TCPS program who are trained in the basics of first aid to give my child first aid when appropriate.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize TCPS to transport my child to the nearest medical care facility and to secure necessary medical treatment for my child. I understand that I assume all financial responsibility for any treatment or injuries sustained by my child while he/she is in TCPS care.

Child's Physician Name: _____

Address: _____

Phone Number: _____

My insurance provider is _____

Insurance Provider Number: _____

Chronic Health Conditions: _____

My child is taking the following medications

My child has the following allergies

Signature of Parent or Guardian

Date

Signature of Program Director

Date

Administration of Medication Consent Form

INSTRUCTIONS:

1. All prescriptions and nonprescription medications shall be maintained with the child's name and shall be dated.
2. Prescriptions and nonprescription medications must be stored in the original bottle with unaltered label. Medications requiring refrigeration must be properly stored.
3. Prescription and nonprescription medication shall be administered in accordance with the label directions.
4. Written Consent must be provided from the parent, permitting TCPS staff to administer medications to the child. Instructions shall not conflict with the prescription label or product label directions.

First & Last Name of CHILD: _____

Type/Name of Medication:	Prescription #:	Dosage:	Route (method)*:
Start date:	End Date:	Times & frequency:	

REASON:

I authorize TCPS staff to administer the medication, to the child listed, according to the instructions listed above.

POSSIBLE SIDE EFFECTS TO WATCH FOR WITH THIS MEDICATION:

Date of authorization:

Signature (parent/guardian):

**ALL PHYSICAL
FORMS MUST BE
COMPLETED AND TURNED
IN TO THE COMMON PLACE
OFFICE **PRIOR** TO THE
START DATE.**

**A STATEMENT PERTAINING
TO NO KNOWN CONTACT,
NO KNOWN EXPOSURE OR
NEGATIVE TESTING
RESULTS FROM COVID 19
MUST BE SUBMITTED WITH
PHYSICAL ACCOMPANIED
BY A DOCTOR'S SIGNATURE**

**Any questions, feel free to contact the Common Place office at
(267) 275-8238.**

Child Health Assessment Form

Child's Name (Last)	(First)	Parent/Guardian
Date of Birth	Home Phone	Cell Phone
Address	City/State/Zip	Work Phone
Child Care Facility Name	Address	City/State/Zip
Facility Phone	County	
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. Also, parents you may write immunization dates, but health professionals should verify and complete all data.	PA Child Care providers must document that enrolled children have received age appropriate health services and immunizations that meet the current schedule of 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 #95355 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:
Allergies to food or medicine:	Describe, if any:	Do not omit any information. This form may be updated by health professional.
Height/Weight ____ In/Cm ____% ILE ____ Lb/Kg ____% ILE	Head Circumference (Birth to Age 2) ____ In/Cm ____% ILE	Blood Pressure (Beginning at Age 3) ____ / ____
Physical Examination	Check, if Normal	If Abnormal, Explain
Head/Ears/Eyes/Nose/Throat		
Teeth		
Cardio respiratory		
Abdomen/GI		
Genital/Breasts		
Extremities/Joins/Back/Chest		
Skin/Lymph Nodes		
Neurologic & Developmental		
Screening Tests	Date Test Done	Note Here if Results are Pending or Abnormal
Lead		
Anemia		
Urinalysis		
Hearing		
Vision		
Professional Dental Exam		
Immunizations	Date	Date
Dta/DTp/Td		
Polio		
HIB		
HEP B		
MMR		
VARICELLA		
PNEUMOCOCCAL		
Other		
Health Problems or Special Needs, Recommended Treatment/Medications/Special Care (Attach additional sheets if necessary):		
Next Appointment-Month/Year:		
Medical Care Provider:	License Number:	
Address:	City/State/Zip:	
Phone:	Date Form Signed:	

Signature of Physician or CPNP: _____