BOYS & GIRLS CLUBS
OF THE CAPITAL AREA

Albany LEAPS Afterschool Program Registration Form

The goal of the afterschool program is to provide quality academic support and enrichment opportunities. Through hands-on projects and guided activities, participants will engage in **academic tutoring, health & wellness, STEM, literacy, recreation, arts & crafts, and social-emotional learning.**

September 14 - June 17
Monday - Friday
Snack and dinner served daily

ASH
2:30-5:30pm
Hannah Villanueva
(518) 866-3825
hvillanueva@bgccapitalarea.org

PHES
2:30-5:30pm
Erykah Thompson
(518) 362-9178
ethompson@bgccapitalarea.org

TOAST
2:30-5:30pm
Tajiya Davis
(518) 362-9175
tdavis@bgccapitalarea.org

DCS
3:30-6:30pm
Chimere Bovian
(518) 866-3534
cbovian@bgccapitalarea.org

AHES
3:30-6:30pm
Venus Johnson
(518) 362-9177
vjohnson@bgccapitalarea.org

Attendance Policy
Regular attendance is required. Three or more unexcused absences or early dismissals may result in removal from the program. This is not a drop-in program.

Dismissal Procedures
Children must be picked up by an approved adult at dismissal or use school transportation home. Repeated late pickups and failure to comply with dismissal procedures may result in dismissal from the program.

Transportation
Please request a bus application if transportation services are needed. Enrolled students are eligible for free district transportation home each evening or may be picked up daily, regardless of whether they qualify for regular transportation in their district.

Behavior Expectations
To ensure a safe, respectful, and positive environment, all participants must follow the behavior guidelines outlined in the Parent Handbook. Failure to meet expectations may result in suspension or dismissal based on the severity or frequency of the behavior.

Enrollment
This program is not first-come, first-served. Submitting an application does not guarantee enrollment. You will be notified once your child has been accepted into the program.

Staff
All staff are cleared by the Office of Children & Family Services. Staff will participate in ongoing professional development and training as part of their commitment to the program.

Must be enrolled in the school to attend the program

Please sign and date below acknowledging that you have read the above information.

Student Name _____

Parent/Guardian Name _____

Parent/Guardian Signature _____ Date _____

BOYS & GIRLS CLUBS OF THE CAPITAL AREA

Clubhouse Afterschool Program Registration Form

ALL FIELDS MUST BE COMPLETED - FAILURE TO DO SO MAY DELAY ENROLLMENT

Child Information

First Name _____ Last Name _____
Address _____ City _____ State _____ Zip _____
School _____ Grade/Teacher
DOB _____ ☐ Male ☐ Female ☐ Non-Binary
Check all that apply: ☐ Hispanic/LatinoBlack/African American ☐ Biracial/Multiracial
☐ White ☐ Indian/Native Alaskan ☐ Asian/Pacific Islander ☐ Other _____

Sibling's Name(s) _____ Age _____ Registered for Program: ☐ Yes ☐ No
_____ Age _____ Registered for Program: ☐ Yes ☐ No

Parent/Guardian #1 (all correspondence will be delivered to this party)

First Name _____ Last Name _____
Legal Guardian ☐ Yes ☐ No Cell ( ) - Home ( ) - Work ( ) -
Address _____ City _____ State _____ Zip _____
Email _____ DOB _____ ☐ Male ☐ Female ☐ Non-Binary

Parent/Guardian #2

First Name _____ Last Name _____
Legal Guardian ☐ Yes ☐ No Cell ( ) - Home ( ) - Work ( ) -
Address _____ City _____ State _____ Zip _____
Email _____ DOB _____ ☐ Male ☐ Female ☐ Non-Binary

PLEASE NOTE: Parents or guardians listed above have permission to pick up the child. A court order is required if a parent is denied access to the child. Child lives with:
☐ Both Parents ☐ Mom ☐ Step Mom ☐ Dad ☐ Step Dad ☐ Grandparent
☐ Foster Parent ☐ Other: _____

Do you live in a housing development? If yes, which one? _____
Are any of the child's parents actively serving in the Military? Yes No If yes, which branch? _____

Household Income Level (this information is collected for grant writing purposes only):
☐ $0-$5,000 ☐ $5,001-$10,000 ☐ $10,001-$15,000 ☐ $15,001-20,000
☐ $20,001-$25,000 ☐ $25,001-$30,000 ☐ $30,001-$35,000 ☐ $35,001-$40,000
☐ $40,001-45,000 ☐ $45,001-$50,000+
Number in Household _____ Number in Household under 18 _____ Single Parent? ☐ Yes ☐ No
Female Head of Household? ☐ Yes ☐ No Household includes a senior (65+)? ☐ Yes ☐ No
Households include person(s) with a disability? ☐ Yes ☐ No Number of household members: _____
Child receives ☐ free lunch ☐ reduced cost lunch

Emergency Contacts (three individuals who may pick up your child if you cannot be reached)

As a regulated program operating under OCFS requirements, we are required to collect three emergency contacts for each child

Emergency Contact #1

First Name _____ Last Name _____

Relationship _____ Cell ( ) - _____ Home ( ) - _____ Work ( ) - _____

Address _____ City _____ State _____ Zip _____

Emergency Contact #2

First Name _____ Last Name _____

Relationship _____ Cell ( ) - _____ Home ( ) - _____ Work ( ) - _____

Address _____ City _____ State _____ Zip _____

Emergency Contact #3

First Name _____ Last Name _____

Relationship _____ Cell ( ) - _____ Home ( ) - _____ Work ( ) - _____

Address _____ City _____ State _____ Zip _____

Medical Information

Doctor's Name _____ Doctor's Phone _____

Permission for Treatment by Doctor/Hospital: ☐ Yes ☐ No Preferred Hospital: _____

Allergies (additional medical information required): ☐ Yes (please complete IHCP form) ☐ No

Please explain: _____

Child Requires EPIPen stored on site: ☐ Yes (please complete A&A form) ☐ No

Food Intolerance/Restrictions? ☐ Yes ☐ No

If yes, please explain: _____

Asthma: ☐ Yes (please complete IHCP form) ☐ No

Child Requires Inhaler to be stored on site: ☐ Yes (please complete IHCP & medication forms) ☐ No

Any additional medical information you would like us to know about your child:

_____

_____

Continued on next page

Emergency/Accident Procedures/Illness

Please read & initial each statement and sign at the bottom

_____ If your child is not feeling well, we will call and ask that you come pick him or her up from the program. If we are not able to contact you, we will contact someone on your authorized emergency contact list until we reach someone to pick up your child

_____ I am aware the program can only administer emergency medication as prescribed by a physician and as indicated on the individual health care plan provided. The staff will not administer non-emergency medications.

_____ I am aware that if I cannot be reached in the event of an emergency I am responsible for full payment of hospital bills if my child is transported to the hospital. Included but not limited to; ambulance transport, surgeries, etc.

_____ In the event of a medical emergency, I understand every effort will be made to contact a parent or guardian. If I cannot be reached, I grant permission to the physician selected by staff to hospitalize, secure proper treatment, and order injection, anesthesia or emergency surgery for my child named above.

Parent/Guardian Signature _____ Date_____

Acknowledgments

Please read & initial each statement and sign at the bottom

_____ The program shall not be responsible or legally liable for any losses, theft or damages to personal property or for any bodily injuries or the results thereof, incurred and suffered by the applicant on any property of the program.

_____ I understand that the Parent Handbook is available online and at the front desk

_____ I understand that my child's attendance is essential to achieve academic and enrichment goals.

_____ I agree to notify BGCCA staff if my child is going to be absent. If a child is absent for a week without notice they may be placed back on the waiting list or lose their spot in the program. I understand and agree to the attendance policy.

_____ I agree to keep registration forms updated throughout the year.

_____ I give permission for my child to be released from the childcare program with the individuals listed on the prior page. I understand that people listed are required to show identification for a child to be released. I also agree to notify the childcare program staff in advance when I will not be picking up my child.

_____ I give permission for my child to carry and use sunscreen.

_____ If a child purposefully breaks, damages or steals any property, the parent/guardian will be held responsible for making financial restitution for the full amount of said item(s).

_____ I give permission to the childcare program to contact my child's school to obtain academic records so they can monitor my child's progress and evaluate specific program goals.

_____ I give permission for my child to participate in computer programming and access the Internet following all standards set forth by the childcare program; I will not hold the childcare program liable for any materials acquired on the Internet.

_____ I give permission for my child to go with any academic teacher/tutor at any time during program hours.

_____ I give permission for my child to participate in walking field trips to outdoor locations. Opt out forms will be sent home one week prior to the field trip date.

_____ I give consent for my child to participate in an anonymous survey to collect informational feedback about their experiences with the program. Child's name will not be collected and will never be connected with any responses.

Parent/Guardian Signature _____ Date_____

Photo/Media Release

The school systems and BGCCA make efforts to promote the positive activities, honors and work of our staff & students. Publications and marketing materials, websites, and the media, may all be utilized as tools for such promotion. There may be opportunities where students will be photographed and identified by name and school. We understand that some parents may request that we do not identify their children.

_____ Yes, I (parent/student) _____ do hereby give consent to photograph my child or myself (if I am a student 18 years of age or older) for use in any and all publications, including newsletters, calendars, media projects, brochures, school, district or BGCCA websites, or any other broadcast, online or publication media.

_____ No, I (parent/student) _____ hereby prohibit any photograph of my child or myself (if I am a student 18 years of age or older) for use in any and all publications, including newsletters, calendars, media projects, brochures, school, district or BGCCA websites, or any other broadcast, online or publication media.

Parent/Guardian Signature _____ Date _____

If a situation arises that may change your child's status regarding publicity, please notify the BGCCA Site Coordinator, school and the District Communications Office in writing as soon as possible.

Affirmation

I affirm that the information included in this application is true and complete to the best of my knowledge. I understand that completing this application does not guarantee my child enrollment. Upon acceptance into the program, I, as parent or guardian, agree to attend any meetings or orientations that may be required by the program.

Parent/Guardian Signature _____ Date _____

NYS Learning and Enrichment

After-School Program (LEAPS)

BOYS & GIRLS CLUBS OF THE CAPITAL AREA

Technology Acceptable Use Policy - Parent/Guardian Consent Form

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Dear Parent/Guardian,
We are excited to provide new Chromebooks to enhance learning opportunities for students in our **NYS Learning and Enrichment After School Program (LEAPS)** at your child's school. LEAPS is operated by Boys & Girls Clubs of the Capital Area (BGCCA) as a New York State-funded after-school program.

Before your child can use these devices, both you and your child must review and acknowledge the Technology Acceptable Use Policy.

Key points from the policy:

- Devices are for educational and program purposes only during after-school hours
- Use is monitored and restricted to approved times and locations
- Parents may be present during any device inspections
- The program is not liable for loss, damage, or theft of any personal devices brought to the program
- Violations may result in disciplinary action

Please complete the following:

☐ I have read and discussed the complete Technology Acceptable Use Policy with my child.

☐ I permit my child to use program technology equipment and wireless internet access during the LEAPS after-school program.

☐ I understand the program may monitor, inspect, and review devices used in the program with my notification.

☐ I understand the program is not responsible for loss, damage, or theft of any personal devices my child brings to the program.

- OR-

☐ I wish to opt out my child from utilizing club appropriate technology during the program.

☐ I acknowledge that my child will participate in an alternative lesson/activity that does not utilize technology/chromebooks/etc during program hours

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Child/Student Name: _____ School: _____

Parent/Guardian Name(Print): _____

Parent/Guardian Signature: _____ Date: _____

Child/Student Signature: _____ Date: _____

NYS Learning and Enrichment

After-School Program (LEAPS)

BOYS & GIRLS CLUBS OF THE CAPITAL AREA

Technology Acceptable Use Policy - Parent/Guardian Consent Form

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Please return this signed form to your child's after-school program staff by 12/12/2025. Your child will not be able to use the Chromebooks until we receive this completed form.

A copy of the complete Technology Acceptable Use Policy is attached for your review and records.

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***)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ 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: / /

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

You may use this form or an approved equivalent to document an individual health care plan developed for a child with special health care needs.

A child with a special health care need means a child who has a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and who requires health and related services of a type or amount beyond that required by children generally.

Working in collaboration with the child's parent and child's health care provider, the program has developed the following health care plan to meet the individual needs of:

CHILD NAME:	CHILD DATE OF BIRTH: / /
NAME OF THE CHILD'S HEALTH CARE PROVIDER:	☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner

Describe the special health care needs of this child and the plan of care as identified by the parent and the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment.

Identify the caregiver(s) who will provide care to this child with special health care needs:

Caregiver's Name	Credentials or Professional License Information (if applicable)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

Describe any additional training, procedures or competencies the caregiver identified will need to carry out the health care plan for the child with special health care needs as identified by the child's parent and/or the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment. In addition, describe how this additional training and competency will be achieved including who will provide this training.

This plan was developed in close collaboration with the child's parent and the child's health care provider. 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:	FACILITY ID NUMBER:	PROGRAM TELEPHONE NUMBER: ( )
CHILD CARE PROVIDER'S NAME (PLEASE PRINT):		DATE: / /
CHILD CARE PROVIDER'S SIGNATURE: **X**		

I agree this Individual Health Care Plan meets the needs of my child. Yes ☐ No ☐

I give consent to share information about my child's allergy with all program caregivers in a non-discreet way. I support the strategies the program implements to keep my child from being exposed to known allergen(s). I acknowledge these strategies may include visual reminders that may result in the disclosure of my child's confidential allergy information to non-child care staff. Yes ☐ No ☐

Signature of Parent:

X	DATE: / /

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICATION CONSENT FORM

CHILD DAY CARE PROGRAMS

- This form may be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays.
- Only those staff certified to administer medications to day care children are permitted to do so.
- One form must be completed for each medication. Multiple medications cannot be listed on one form.
- Consent forms must be reauthorized at least once every six months for children under 5 years of age and at least once every 12 months for children 5 years of age and older.

LICENSED AUTHORIZED PRESCRIBER COMPLETE THIS SECTION (#1 - #18) AND AS NEEDED (#33 - 35).

1. Child's First and Last Name:	2. Date of Birth: / /	3. Child's Known Allergies:
4. Name of Medication *(including strength):*	5. Amount/Dosage to be Given:	6. Route of Administration:

7A. Frequency to be administered: _____

OR

7B. Identify the symptoms that will necessitate administration of medication: *(signs and symptoms must be observable and, when possible, measurable parameters)*: _____

8A. Possible side effects: ☐ See package insert for complete list of possible side effects *(parent must supply)*

AND/OR

8B: Additional side effects:

9. What action should the child care provider take if side effects are noted:
☐ Contact parent ☐ Contact health care provider at phone number provided below
☐ Other *(describe):* _____

10A. Special instructions: ☐ See package insert for complete list of special instructions *(parent must supply)*

AND/OR

10B. Additional special instructions: *(Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situations when medication should not be administered.)* _____

11. Reason for medication *(unless confidential by law)*: _____

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and requires health and related services of a type or amount beyond that required by children generally?

☐ No ☐ Yes If you checked yes, complete (#33 and #35) on the back of this form.

13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered?

☐ No ☐ Yes If you checked yes, complete (#34 -#35) on the back of this form.

14. Date Health Care Provider Authorized: / /	15. Date to be Discontinued or Length of Time in Days to be Given: / /
16. Licensed Authorized Prescriber's Name (please print):	17. Licensed Authorized Prescriber's Telephone Number:

18. Licensed Authorized Prescriber's Signature:
X

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICATION CONSENT FORM

CHILD DAY CARE PROGRAMS

PARENT COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? *(For example, did the licensed authorized prescriber write 12pm?)* ☐ Yes ☐ N/A ☐ No

Write the specific time(s) the child day care program is to administer the medication *(i.e.: 12 pm*): _____

20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to *(child's name):*

21. Parent's Name *(please print)*:	22. Date Authorized: / /

23. Parent's Signature:
X

CHILD DAY CARE PROGRAM COMPLETE THIS SECTION (#24 - #30)

24. Program Name:	25. Facility ID Number:	26. Program Telephone Number:

27. I have verified that (#1 - #23) and if applicable,(#33 - #36) are complete. My signature indicates that all information needed to give this medication has been given to the day care program.

28. Staff's Name *(please print)*:	29. Date Received from Parent: / /

30. Staff Signature:

X

ONLY COMPLETE THIS SECTION (#31 - #32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN (#15)

31. I, parent, request that the medication indicated on this consent form be discontinued on **/ /**
(Date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent Signature: **X**

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #35)

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.

34. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date you are ordering the change in the administration of the prescription to take place.

DATE: / /

By completing this section, the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

35. Licensed Authorized Prescriber's Signature: **X**