



Advocacy and Services for People with Disabilities
Oneida-Lewis Chapter NYSARC

Administrative Offices: 245 Genesee Street, Utica NY 13501

Reading, Math and After School Learning Program

Application

Children's Services
Shannon Clark
Children's Programs Coordinator
315.272.1588

Application

Reading ___ Math ___ After School Learning ___ (please check one)

Name of child _____

DOB: _____ Age: _____ Gender: _____ SS # _____

Home Address _____ City _____ Zip _____

Home Telephone #: _____ Other Telephone #: _____

Email _____

Primary Disability: _____

Parent/Caregiver's name: _____

My child has my permission to leave with the following person(s) with a valid photo ID such as a driver's license.

EMERGENCY CONTACT INFORMATION

Name _____

Address _____ Relationship _____

Other _____ Telephone _____

MEDICAL INFORMATION

Primary Care Physician: _____ Telephone _____

Preferred Hospital _____

1. Insurance Information : Type: _____ ID# _____

Name of Insured: _____

2. Note any special dietary needs/restrictions (Please bring any special dietary snacks with you).

3. Does the child have seizure like activity Yes _____ No _____

4. Is there any other pertinent medical information you feel we should know about the child?

ALLERGIES Yes _____ No _____

_____Foods _____Medications _____Insects (bee stings, etc.) _____Other (dust, animals, etc.)

Milk (Dairy Products) _____ Peanut Butter _____ Sun Precautions _____

Specify allergy and reaction _____

MEDICATIONS

Name all medications taken, include dosage, and times taken _____

OTHER

Is your child with a disability receiving services from any agency? (please circle one) Yes No

What Service(s)? _____ What Agency: _____

Does your child with a disability receive medicaid? (please circle) Yes No

Medicaid number: _____ Service Coordinator name: _____

Would you like to have someone from The Arc, Oneida-Lewis Chapter, NYSARC contact you about the services we offer?
(please circle) Yes No

Parent / Caregiver Permission:

I hereby give / do not give (please circle one) my permission to allow the child / children named on this application to be photographed during the Reading, Math and After School Learning Program sessions. I understand the photos may be used to promote the program.

I hereby give / do not give (please circle one) my permission for emergency medical treatment by staff and/or a physician in case of a medical emergency involving the child/children on this application. I also give permission for an ambulance to be called if necessary. I will be responsible for any expenses arising from such emergency.

Parent/caregivers signature

Date