# Youth Programs Application

University of Massachusetts Boston

100 Morrissey Blvd
Boston, MA 02125
P: 617.287.5000
www.umb.edu/youth_programs

## Instructions

Participant's Full Name ______________________________

Program's Name ______________________________

Date Submitted ______________________________

If you are applying to a youth program at the University of Massachusetts Boston, please complete and mail the following application packet to the address below:

University of Massachusetts Boston
100 Morrissey Boulevard
Boston, MA 02125

**Failure to complete all forms in the application may result in your child not being accepted into the youth program**:

| Sections | Required | Completed |
|---|---|---|
| Policies and Guidelines | YES | ☐ |
| Contact Information | YES | ☐ |
| Release Forms | YES | ☐ |
| Health: History & insurance | YES | ☐ |
| Health: Consents Treatment & OTC | YES | ☐ |
| Physical & Immunization Records | YES or Attached | ☐ |
| Authorization to Administer Medication | NO | ☐ |

**UNIVERSITY OF MASSACHUSETTS BOSTON**

# Policies and Guidelines

Youth Summer Programs | University of Massachusetts Boston

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**Participant's Full Name** ______________________________________________

## University Policies and Guidelines

**PERMISSION TO PARTICIPATE** When you signed your child's medical form, you gave permission for your child to participate in all program activities. If you wish for your child to be restricted from any activity, please notify us in writing prior to your child's program session. Please note that it is not our policy to force any child to participate in an activity**.** We do our best to make the activity enjoyable so your child will wish to participate.

**MEDICAL CONCERNS** All participants are required to have a completed application packet including UMass Boston's health history, immunizations, consent to treat minor patient, and authorization to administer medication forms on file before the program begins. Please be sure that you complete these forms and that your child's healthcare provider has signed that a physical examination has been conducted within the last 24 months. Please provide us with as much information as possible concerning your child's medical history, allergies, medications, and any special needs. All medical forms must include an up-to-date immunization record and must be signed by a healthcare provider.

**MEDICATION** Every effort should be made to administer routine medications at home in order to prevent disruption in your child's daily program activities. However, if your healthcare provider believes that it is in the best medical interest of your child to administer them during the program's hours, please submit the completed Authorization to Administer Medication form. A separate form must be completed for each medication. State law does not permit administration of medication during the program hours without written authority by the prescribing healthcare provider. Youth program participants are at no time allowed to carry any kind of medication, be administered medication without official written directive from the prescribing healthcare provider, or take medication without direct youth program supervision.

**SAFETY PROCEDURES** Whenever possible, we bring outdoor activities into air-conditioned facilities, or to cool, shaded areas. Our first concern is for your child's safety; therefore, we reserve the right to take the following actions in very hot weather: reduce physical activities, substitute outdoor activities for sedentary activities, and provide activities unrelated to your child's specialty (e.g., movies).

**MEDICAL NOTIFICATION** It is our policy to notify you if your child becomes ill during the youth program or suffers an injury other than minor bumps, bruises or scrapes.

**VALUABLES** We recommend that program participants not bring large sums of money or other valuables to UMass Boston. The University is not responsible for lost or stolen personal items.

**SUNSCREEN** The use of sunscreen is highly recommended by University Health Services. It is best to apply sunscreen to your child before he or she leaves home in the morning. You may wish to send along additional sunscreen to be applied later in the day.

**INAPPROPRIATE** BEHAVIOR UMass Boston reserves the right to dismiss any participant who acts in an inappropriate or detrimental manner including bullying, harassing, intimidating, or threatening to other individuals.

## Permission and Certification

I, the undersigned, hereby give my permission for my son/daughter to participate in all the activities of the *(program)* ________________________________ at UMass Boston from the date of his/her acceptance throughout his/her involvement with the program.

We (participant and I) agree to support the administrative rules of the *(program)* ______________________________________ , the above referenced UMass Boston policies and guidelines, and to cooperate with the staff to our fullest extent.

Further, by signing below, I attest to the fact that all of the information provided by me or any other person on this application is true and complete to the best of my knowledge.

| **Parent/Guardian** | | | |
|---|---|---|---|
| | **Signature** | **Printed Name** | **Date** |

# Contact Information

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**Participant's Full Name** ______________________________

## Student Contact Information

Address ______________________________
Number | Street Name | Apartment | City, State | Zip

Contact ______________________________
Student Cell Telephone | Student Email address

Date of Birth (M-D-Y) ____________ Gender ☐ M ☐ F Participant knows how to swim ☐ Y ☐ N

Name of School (This School Year) ____________ Grade (This School Year) ____________

Language(s) spoken at home ____________ Ethnicity ____________

Hair Color ____________ Eye Color ____________ Height ____________ Weight ____________

## Parent/Guardian Contact Information

Primary Parent/Guardian ______________________________ Relationship ____________
Last | First | Middle

Address ______________________________
Number | Street Name | Apartment | City, State | Zip

Contact ______________________________
Home Telephone | Cell/Work Telephone | Email address

Other Parent/Guardian ______________________________ Relationship ____________
Last | First | Middle

Address ______________________________
Number | Street Name | Apartment | City, State | Zip

Contact ______________________________
Home Telephone | Cell/Work Telephone | Email address

## Emergency Contact Information

Please list two (2) emergency contacts different from the parent(s) listed above, who will be available during program hours.

Emergency Contact #1 ______________________________ Relationship ____________
Last | First | Middle

Contact ______________________________
Home Telephone | Cell/Work Telephone | Email address

Emergency Contact #2 ______________________________ Relationship ____________
Last | First | Middle

Contact ______________________________
Home Telephone | Cell/Work Telephone | Email address

**Parent/Guardian** ______________________________
**Signature** | **Printed Name** | **Date**

# Summer TAG Information

Youth Summer Programs | University of Massachusetts Boston

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**Participant's Full Name** ____________________________________________

## RELEVANT STUDENT INFORMATION

Name of School (NEXT Year) ______________________ Grade (NEXT Year) ______________

How long have you been in the United States? ☐ Born and raised in the USA ☐ ______________ years/ months

BPS Student Number |__|__|__|__|__|__| Do/would you receive FREE or REDUCED lunch at school? ☐ Yes ☐ No

## SPECIAL EDUCATION

TAG does NOT provide SPECIAL EDUCATION services. Does student have an IEP?

Does student have an IEP? ☐ No ☐ Yes, I will provide the IEP

## ACADEMIC INFORMATION

What **MATH** course did the student take this year?

☐ Pre-Algebra ☐ Algebra 1 ☐ Geometry ☐ Algebra 2 ☐ Pre-Calc

**Pass/Fail Math:** ☐ Pass ☐ Failed ☐ Unsure **Next Year** the student will take (Math) ______________

***SPELL ONLY***: What **ESL** course did the student take this year?

☐ ESL 1 ☐ ESL 2 ☐ ESL 3 ☐ ESL 4/5

**Pass/Fail ESL:** ☐ Pass ☐ Failed ☐ Unsure **Next Year** the student will take (ESL) ______________

## ENROLLMENT PLANS

**FREE FOR BOSTON PUBLIC SCHOOL (BPS) DISTRICT STUDENTS IN 6-12 GRADE.** Students who are not enrolled in BPS (charter, private or parochial students) may apply to EXCEL for a $200 fee. Acceptance is not guaranteed. Please select the component of Summer TAG in which you would like to enroll.

| Component | Appropriate for | NOT Appropriate for |
|---|---|---|
| ☐ **EXCEL** | Regular education and/or exam school student in entering grades 7-12 next school year. | Students who need summer school credit; are taking ESL/ELD courses; have an IEP that requires lower than a 1:15 staff-student ratio or special education services. |
| ☐ **SPELL** | English Language Learners enrolled in BPS. This program offers summer school credit if needed. | Students who do not attend a school within the BPS district; have an IEP that requires lower than a 1:15 staff-student ratio or special education services. |

## LUNCH

Lunch is not included in the program. Please indicate your lunch plans.

☐ **HOME LUNCH**
The student will bring la healthy lunch from home daily.

☐ **TAG LUNCH PLAN: $45 FEE**
The TAG lunch plan that provides a sub and water daily for an at-cost fee ($45), except on field trip and graduation days. Sub options include Chicken, Ham & Cheese, Turkey & Cheese, or Tuna, and are available first come first serve, unless a special diet is indicated on the medical forms.

# BPS Records Dissemination Consent

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## BOSTON PUBLIC SCHOOLS
## PARENT'S OR STUDENT'S CONSENT FOR DISSEMINATION OF STUDENT RECORD TO THIRD PARTY

Adopted from Superintendent's Circular #LGL-7, 2013-2014

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I give permission for the following third parties to ☐ Inspect ☐ Secure a copy of

The parts of my/my child *(student name)* ______________________________ 's student record noted below.

THIRD PARTIES:
Institute for Learning and Teaching of UMass Boston

REASONS FOR RELEASE OF RECORDS:
In consideration of the student's participation in the Talented And Gifted Latino Program, an academic and youth development partner to the Boston Public Schools, release of the student's current and past school records is requested. Access to student records will allow the Talented And Gifted Latino Program to better support the student and obtain necessary data to measure effectiveness and impact.

| PARTS OF RECORD TO BE RELEASED* | PERMISSION GRANT | PERMISSION DENIED |
|---|---|---|
| Transcript information (includes identifying information, course titles, grades or their equivalent, and grade level completed) | ☐ | ☐ |
| Disciplinary record | ☐ | ☐ |
| Extracurricular activities | ☐ | ☐ |
| Teacher and counselor evaluations and comments | ☐ | ☐ |
| Attendance record | ☐ | ☐ |
| Other (specify) | ☐ | ☐ |

| ****Signature of Student or Parent/Guardian** | **Student's Graduation Class** | **Date** |
|---|---|---|
| | | |

* Before seeking the parent's or eligible student's consent, the school should cross out those items which have not been requested by the third party

** This form may be signed by a student or former student of fourteen years of age or older, or a student in the ninth grade or above, or a custodial parent or guardian.

# Release Forms

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**Participant's Full Name** ______________________________

**Please read the following releases carefully and provide a signature for each section below. You may ONLY opt-out of the Media Release.**

## REQUIRED: General Release

I, ______________________ as the parent/legal guardian of ______________________ *(student)* in consideration of my child being allowed to participate in the ______________________ *(program)* on behalf of my child, myself, my family, my heirs, representatives, assigns, executors or administrators, I hereby release and agree to hold UMass Boston, its trustees, directors, officers, employees, servants, representatives, agent licensees, successors and assigns, harmless from and against any and all claims, losses, damages, expenses (including attorneys' fees, and all court and litigation costs) and liability (including statutory liability), resulting from injury and/or death of any person or damage to or loss of any property arising out of or in any way from the ______________________ *(program)* and my child's participation therein.

| **Parent/Guardian** | | | |
|---|---|---|---|
| | **Signature** | **Printed Name** | **Date** |

## REQUIRED: Release to Participate in Program Activities

I hereby give permission for my son/daughter to participate in all activities, including field trips, in the youth programs including transportation to and from UMass Boston including program related activities from the date of his/her acceptance throughout his/her involvement with the program, and I hereby certify that the statements on this form are true to the best of my knowledge and belief. We further agree to support the administrative rules of the program and to cooperate with the staff to our fullest extent.

| **Parent/Guardian** | | | |
|---|---|---|---|
| | **Signature** | **Printed Name** | **Date** |

## OPTIONAL: Media Release

Beginning as of the date of execution of this release, that photographs, whether still or action, videos, film and/or motion pictures (hereinafter "Pictures") and/or audio recordings ("Recordings") may be taken of my child, individually or with others, by or on behalf of UMass Boston in connection with this youth program, and agree that all rights therein shall irrevocably, exclusively, unconditionally and perpetually belong to UMass Boston and that such rights are freely assignable by UMass Boston. I further agree that, without any compensation or notification to or approval by me, the Pictures or Recordings, and website postings may be used, reproduced or otherwise disseminated or published by or on behalf of UMass Boston directly or indirectly for any purpose, including but not limited to advertising and/or promotional purposes, in any manner, and at any time that UMass Boston desires. For good and valuable consideration, receipt of which is hereby acknowledged, I hereby agree to release and discharge UMass Boston, its trustees, directors, officers, employees, servants, representatives, agents, licensees, successors and assigns from any and all claims, demands or causes of action that I may now have or may hereafter have for libel, defamation, invasion of privacy or right of publicity, infringement of copyright or violation of any other right arising out of or relating to any utilization of the Pictures or Recordings.

| **Parent/Guardian** | | | |
|---|---|---|---|
| | **Signature** | **Printed Name** | **Date** |

# Health: History & Insurance

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**Participant's Full Name** ___________________________________________

**As a youth participant, parent or guardian I understand that** the information requested on this form is intended to help inform staff of any pre-existing medical conditions. If your child has a pre-existing medical condition, participation in any strenuous activity or recreational time may not be recommended. *This information will be kept in strict confidence and will only be shared with your permission.* UMass Boston requests the information below so that, in case of an emergency, we will have accurate information so that we can provide and/or seek appropriate treatment. You are accountable for providing an accurate medical history. *Final determination about whether to participate is the responsibility of UMass Boston's consulting health care provider.* If you have any medical issue that is not requested below, but which you think is important, please include that information.

## TO BE COMPLETED BY A PARENT/GUARDIAN

### Health History

Has the participant had, or does the participant have, any of the following? Mark "Y" for Yes and provide a brief explanation, or mark "N" for No.

- ☐ Y ☐ N Heart disease/ heart defect
- ☐ Y ☐ N High blood pressure
- ☐ Y ☐ N Seizures/epilepsy/fainting spells
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Concussion or serious head injury
- ☐ Y ☐ N Heat stroke/exhaustion
- ☐ Y ☐ N Contact lenses/glasses
- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Easy Bleeding
- ☐ Y ☐ N Emotional/psychiatric/behavioral Issues
- ☐ Y ☐ N Sickle cell trait or disease
- ☐ Y ☐ N Food allergies or special diet
- ☐ Y ☐ N Other allergies
- ☐ Y ☐ N Limitations that restrict running, swimming, or participating in group recreational activities

Please explain all "Y's" below and use this space to provide any additional information on the youth's physical, behavior or emotional/ mental health of which the program and University should be aware:

___________________________________________

___________________________________________

___________________________________________

Will the student need to take medication during program hours? ☐ No ☐ Yes, instructions are provided below*

**Please note that the optional "Authorization, Waiver and Consent for Over-the-Counter Medication" on page 7 and/or the "Authorization to Administer Prescription Medication" on page 9 must be completed in order for medication to be administered.*

___________________________________________

___________________________________________

***FEMALES ONLY:* Are you pregnant?** ☐ No ☐ Yes, my estimated due date is ____________________

### Health Insurance Information

Please include a copy of the student's health insurance card. If you cannot provide the requested health insurance card, please provide the following insurance information.

Insurance Carrier ____________________ Policy Number ____________ Cardholder's Name ____________________

### Please Read

As a participant, parent or guardian I understand and acknowledge that my failure to disclose relevant informational result in dismissal from a UMass Boston summer youth program. By signing my name I represent and warrant that I have provided all materials and important information to UMass Boston pertaining to my child's medical and physical condition and that it is accurate and complete. I agree to notify the program nurse of any changes in my mental, physical, or medical condition prior to my child's scheduled program.

**Parent/Guardian** ___________________________________________

**Signature** **Printed Name** **Date**

# Health: Consents

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**Participant's Full Name** ______________________________________________

## TO BE COMPLETED BY A PARENT/GUARDIAN

### Consent to Treat Minor Patients

Your child has been accepted to a youth summer program at the University of Massachusetts Boston. University Health Services offers first aid to minors who are participating in university sponsored youth programs. Massachusetts law requires consent of a parent/legal guardian for medical care of minors, including first aid. Please complete the following consent form to allow University Health Services to provide first aid to your child

I, ______________________________________________ am the parent/legal guardian of
______________________________________________ currently a minor, whose date of birth is ____ / ____ / ____ (M D Y)

I authorize the University of Massachusetts University Health Services to provide first aid to the youth. I understand that, should my minor participant need more extensive medical care I will be notified by a healthcare provider through University Health Services. I also understand that if the injury/illness is determined to be life threatening or require immediate medical attention beyond first aid, that an ambulance will be called to take my child to the hospital and that the provider will make every effort to contact me.

By signing this, I acknowledge that I have read and that I understand this consent, and that any questions that I have prior to signing could be answered by calling University Health Services at (617) 287-5660.

| **Parent/Guardian** | | | |
|---|---|---|---|
| | **Signature** | **Printed Name** | **Date** |

### OPTIONAL: Authorization, Waiver and Consent for Over-the-Counter Medication

Over-the-Counter (OTC) Medication may at times need to be administered, if the participant's parents or guardian indicates approval. Please complete the following section to save time if your child needs any of these OTC medications during his/her stay. Note: Unless we have parental authorization, we cannot administer ANY medications.

I hereby authorize that the following medications may be given to my child if the need arises. You may dispense only those checked:

☐ Acetaminophen ☐ Ibuprofen ☐ Benadryl ☐ Triple Antibiotic Ointment ☐ Calamine Lotion ☐ Hydrocortisone Ointment

The following medications can be administered to summer youth participants following emergency medication specific protocol:

☐ Acetaminophen ☐ Albuterol Inhaler ☐ Albuterol Sulfate Inhalation Solution ☐ Epi-Pen Jr. or Epi-Pen
☐ Tylenol/Acetaminophen as directed

I understand that such administration will be done under the supervision of medical personnel.

Any condition which is associated with fever, significant inflammation, and/or does not respond to the above outlined treatment will be followed-up by a consultation with the youth's parents. The parent/guardian will be contacted if any conditions develop requiring treatment with any of the above over-the-counter medications that are not checked.

I authorize the administration of over-the-counter medications to my child as indicated above.

| **Parent/Guardian** | | | |
|---|---|---|---|
| | **Signature** | **Printed Name** | **Date** |
| Contact Information | | | |
| | Home Phone | Cell Phone | Work Phone |

# Physical & Immunization Records

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**Participant's Full Name** ______________________________________________

**PARENT/GUARDIAN must submit medical documentation OR have HEALTHCARE PROVIDER complete below.**

## Physical Form

Please have a healthcare provider (physician, nurse practitioner, physician assistant) sign this form OR you may submit a copy of a school physical form signed by a healthcare provider instead. The physical must have occurred within the last 24 months.

☐ I am submitting a School Physical Form (School & Camp Form) signed by a healthcare provider within the last 24 months.

☐ A healthcare provider has completed the information below.

______________________________________ Is physically able to participate in a general/sport program designed for participants with and without disabilities and his/her immunizations are up to date.

Comments/Limitations:

______________________________________________________________

| **Healthcare Provider Signature** | **Printed Name** | **Date** |
|---|---|---|

## Immunization Records

Please fill out the information below OR provide a copy of the participant's immunization records.

☐ I am submitting a copy of my child's official immunization records.

☐ A healthcare provider has completed the information below:

- MEASLES, MUMPS AND RUBELLA (MMR) VACCINE: First dose must be after age 12 months; 2 doses required**.**
- POLIO VACCINE**:** Minimum of 3 doses of either inactivated polio vaccine (IPV) or oral polio vaccine (OPV) are required. If a mix of (IVP/OPV) was used, 4 doses are required

  Completed primary series of polio immunizations? ☐ Yes ☐ No
- DIPHTHERIA AND TETANUS TOXOIDS AND PERTUSSIS VACCINE**:** Minimum of 4 doses of DTaP/DTP/DT or at least 3 doses of Td is required. A booster dose of Td is required for all program participants who will be entering grades 7-10. For participants who will be entering grades 11 and 12, a booster of Td is required if it has been more than 10 years since the last dose of DTaP/DTP/DT/Td. (Tdap is also acceptable.)

  Completed primary series of DTaP/DTP/DT immunizations? ☐ Yes ☐ No
- HEPATITIS B**:** 3 doses of Hepatitis B vaccine are required if born on or after Jan. 1, 1992.

EXCEPTIONS: I am claiming religious or medical objection. Please attach information.

| **Healthcare Provider Signature** | **Printed Name** | **Date** |
|---|---|---|

Address: ______________________________________________

Phone Number: ______________________________________________

# Authorization to Administer Prescription Medications

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**OPTIONAL: Only Required If Prescription Medication Is Necessary.**
**Please Provide Separate Sheets For Reach Medication**

## TO BE COMPLETED BY A PARENT/GUARDIAN

I request that ______________________________________________ *(participant's name)* receive the medication as prescribed below by our licensed healthcare provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the R.N. or other licensed healthcare provider will administer the medication.

Parent/Guardian ______________________________________________

Signature | Printed Name | Date

## TO BE COMPLETED BY THE LICENSED PRESCRIBER

I request that my patient, as listed below, receive the following medication:

Name of participant ______________________________ Date of Birth ________ - ________ - ________

Diagnosis ______________________________________________

Name of Medication ______________________________________________

Prescribed Dosage, Frequency, and Route of Administration

______________________________________________

Time to be taken during program hours (8:45 AM – 2:00 PM)

______________________________________________

Duration of Treatment ______________________________________________

Possible side effects (if any)

______________________________________________

Other recommendations

______________________________________________

**Name of Licensed Prescriber (please print):** ______________________________

**Title of Licensed Prescriber (please print):** ______________________________

**Address:** ______________________________________________

______________________________________________

**Healthcare Provider Signature** **Date**