



Square Roots Application

How did you hear about our program? ☐ Flyer ☐ Website ☐ Teacher/School ☐ Friend or Family
Are you a Castle Square resident? ☐ Yes ☐ No

Admission Date: _____

Child's General Information

First Name: _____ Last Name: _____

Date of Birth _____ Age _____ Gender: ☐ Male ☐ Female ☐ Other

Address _____ City _____ State _____ Zip _____

Neighborhood:

- | | | | |
|---|---------------------------------------|---|---|
| <input type="checkbox"/> Allston/Brighton | <input type="checkbox"/> Back Bay | <input type="checkbox"/> Charlestown | <input type="checkbox"/> Chinatown |
| <input type="checkbox"/> Downtown | <input type="checkbox"/> East Boston | <input type="checkbox"/> Fenway | <input type="checkbox"/> Hyde Park |
| <input type="checkbox"/> Jamaica Plain | <input type="checkbox"/> Mattapan | <input type="checkbox"/> North Dorchester | <input type="checkbox"/> North End |
| <input type="checkbox"/> Roslindale | <input type="checkbox"/> Roxbury | <input type="checkbox"/> South Boston | <input type="checkbox"/> South Dorchester |
| <input type="checkbox"/> South End | <input type="checkbox"/> West Roxbury | <input type="checkbox"/> Other | |

RACE / ETHNICITY (Choose which group best describes your child)

- | | | |
|---|---|--|
| <input type="checkbox"/> Black (Non-Hispanic) | <input type="checkbox"/> Cape Verdean | <input type="checkbox"/> Haitian |
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> Hawaiian/Pacific Islander |
| <input type="checkbox"/> White (Non-Hispanic) | <input type="checkbox"/> Asian | <input type="checkbox"/> American Indian / Alaskan |
| <input type="checkbox"/> African American | | <input type="checkbox"/> Other |

Primary Language Spoken at home _____ Does your child speak English? ☐ Yes ☐ No

School Attending in Fall _____ Current Grade _____

Child's Medical Information

Eye Color _____ Skin Color _____ Hair Color _____ Height _____ Weight _____



Health Insurance Provider _____ ID# _____

Primary Doctor _____ Primary Doctor Number _____

Does your child have any allergies or medical conditions? ☐ No ☐ If yes, please describe:

Does your child have an IEP or Special Education condition? ☐ No ☐ If yes, please describe:

Does your child require any medical attention while on site? ☐ No ☐ If yes, please provide the name of the medication and the action that should be taken:

Guardian's Information

First Name _____ Last Name _____

Relationship to child _____ Date of Birth _____

Primary Phone Number _____ Evening/Work Phone _____

Email _____

Address _____ City _____ State _____ Zip _____

Alternate Guardian Name _____ Last Name _____

Relationship to child _____ Cell Phone _____



RACE / ETHNICITY (Choose which group best describes you)

- | | | |
|---|---|--|
| <input type="checkbox"/> Black (Non-Hispanic) | <input type="checkbox"/> Cape Verdean | <input type="checkbox"/> Haitian |
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> Hawaiian/Pacific Islander |
| <input type="checkbox"/> White (Non-Hispanic) | <input type="checkbox"/> Asian | <input type="checkbox"/> American Indian / Alaskan |
| <input type="checkbox"/> African American | | <input type="checkbox"/> Other |

***Mark the source(s) of Income Documentation:**

***Mark the HOUSEHOLD SIZE box and select ONE of the three income options going across ON THE SAME LINE.**

Example: a **3-person** household with an annual income of **\$17,000** would be marked on the third row, as **Very Low Income**.

☒ 3 Persons ☒ 0 to \$26,450 ☐ \$26,451 to \$44,050 ☐ \$44,051 to \$58,500

HOUSEHOLD SIZE **Very Low Income** **Low-Income** **Low-Moderate Income**
(Including You)

<input type="checkbox"/> 1 Person	<input type="checkbox"/> 0 to \$20,550	<input type="checkbox"/> \$20,551 to \$34,250	<input type="checkbox"/> \$34,251 to \$45,500
<input type="checkbox"/> 2 Persons	<input type="checkbox"/> 0 to \$23,500	<input type="checkbox"/> \$23,501 to \$39,150	<input type="checkbox"/> \$39,151 to \$52,000
<input type="checkbox"/> 3 Persons	<input type="checkbox"/> 0 to \$26,450	<input type="checkbox"/> \$26,451 to \$44,050	<input type="checkbox"/> \$44,051 to \$58,500
<input type="checkbox"/> 4 Persons	<input type="checkbox"/> 0 to \$29,350	<input type="checkbox"/> \$29,351 to \$48,900	<input type="checkbox"/> \$48,901 to \$65,000
<input type="checkbox"/> 5 Persons	<input type="checkbox"/> 0 to \$31,700	<input type="checkbox"/> \$31,701 to \$52,850	<input type="checkbox"/> \$52,851 to \$70,200
<input type="checkbox"/> 6 Persons	<input type="checkbox"/> 0 to \$34,050	<input type="checkbox"/> \$34,051 to \$56,750	<input type="checkbox"/> \$56,751 to \$75,400
<input type="checkbox"/> 7 Persons	<input type="checkbox"/> 0 to \$36,400	<input type="checkbox"/> \$36,401 to \$60,650	<input type="checkbox"/> \$60,651 to \$80,600
<input type="checkbox"/> 8 Persons or more	<input type="checkbox"/> 0 to \$38,750	<input type="checkbox"/> \$38,751 to \$54,550	<input type="checkbox"/> \$54,551 to \$85,800

- | | | |
|---|--|---|
| <input type="checkbox"/> TAFDC | <input type="checkbox"/> CHILD SUPPORT | <input type="checkbox"/> PUBLIC HOUSING: _____
(name of development) |
| <input type="checkbox"/> SSI/SSDI | <input type="checkbox"/> ALIMONY | |
| <input type="checkbox"/> FOOD STAMP | <input type="checkbox"/> SECTION 8 | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> REFUGEE ASSISTANCE | <input type="checkbox"/> UNEMPLOYMENT INS. | |
| <input type="checkbox"/> BPS FREE LUNCH PROGRAM | <input type="checkbox"/> PAYCHECK / W-2 | |

(1)Emergency Contact Name _____ Last Name _____

Relationship to child _____ Cell Phone _____

(2)Emergency Contact Name _____ Last Name _____

Relationship to child _____ Cell Phone _____



Transportation Plan

Your child will depart Castle Square by:

☐ Guardian pick up ☐ Walking home ☐ Public Transportation

Authorized drop off and pick up list:

Name	Relationship	Cell	Home	Email

Guardian Statement of Understanding/Agreement

The following information is important for the safety and protection of your child. Please read this information and sign below.

- I understand that my child will not be released to any person(s) not listed on the enrollment form.
- I understand that my child will not be released to any person(s) who seems to be under the influence of drugs or alcohol.
- I understand that I am not to leave my child at the Castle Square Community Center unless a staff member is there to receive and supervise my child.
- I understand that it is my responsibility to sign my child in the morning and sign my child out before leaving in the afternoon. Sign in/Sign-out sheets are available as you arrive at the program area.
- I understand that my child will not be allowed to leave the program with an unauthorized person. Any person authorized to pick up my child must be listed on this form. Authorization by telephone will not be accepted.
- I understand that the Castle Square Community Center is mandated to report any suspected cases of child abuse or neglect to the appropriate authorities for investigation.
- I understand that Castle Square Community Center staff and volunteers are not allowed to babysit or transport children at any time outside Castle Square Community Center facilities. If a violation of this policy is discovered, the Castle Square Community Center will take immediate disciplinary action toward staff.



CASTLE SQUARE TENANTS ORGANIZATION

I have read and understand the statements above regarding Castle Square Community Center policies and procedures ☐ Yes ☐ No

I have received a copy of the Castle Square Community Center Family Handbook ☐ Yes ☐ No

I have provided a copy of my child's physical and immunization records. (Including Medical Consent Forms for students who have allergies listed above.) ☐ Yes ☐ No

Statement of Authorization

- 1) I hereby give permission for my child to be transported by an approved school bus and/or public transportation when participating in all Castle Square Community Center activities and related field trips.
- 2) I hereby give permission for my child to participate in swimming activities. Assess your child's swimming abilities below. Castle Square Community Center reserves the right to assess your child before swimming activities.

<input type="checkbox"/> Non Swimmer (unable to swim)	<input type="checkbox"/> Intermediate Swimmer (average)
<input type="checkbox"/> Beginner Swimmer (limited)	<input type="checkbox"/> Advanced Swimmer (skilled)
- 3) In the case that your child becomes ill during the program, you will be contacted as soon as possible. If the guardian is unable to be reached, the child's emergency contact will be notified. It is the responsibility of the guardians to arrange for the child to be picked up from the center as soon as possible.
- 4) In the case that your child or anyone in the immediate household of the child develops a reportable communicable disease as defined by the State Board of Health, it is the responsibility of the parent to notify Castle Square Community Center within 24 hours or the next business day in order for Castle Square Community Center to take proper action, except in the case of life-threatening diseases which must be reported immediately.
- 5) I authorize the management and staff of Castle Square Community Center to act for me according to their best judgment in the event of a medical emergency and/or routine medical care. I/we grant permission for emergency medical treatment and/or routine medical care by the Castle Square Community Center staff, a rescue squad, or private physician and/or hospital or emergency health care facility staff, under the same circumstances as above, if needed. Any such action will be taken in the best interest of my child and will be reported to me/us as soon as possible. My signature waives and/or releases Castle Square Community Center from any and all liability and/or financial responsibility for any medical expenses incurred.



CASTLE SQUARE TENANTS ORGANIZATION

- 6) I authorize staff of Castle Square Tenants Organization, Inc. who is trained in the basics of first aid to give my child first aid when appropriate.
- 7) I authorize the application of sunscreen for his or her child by Castle Square Community Center staff.
- 8) I authorize the application of insect repellent for his or her child by Castle Square Community Center staff.
- 9) I hereby give permission for my child's photograph to be taken in connection with activities related to the youth programs at Castle Square Community Center to be used in newsletters, promotional and marketing materials.
- 10) I hereby give permission for the Square Roots program to have access of my child(s) academic records (report card, assessment scores, standardized test scores and/or IEP). Providing authorization to these documents will allow the Square Roots program to use these as supporting data to our in house evaluations. I understand that this information can be used for grant proposals, program evaluation, and marketing purposes.
- 11) I understand that Castle Square Community Center is responsible for maintaining a safe educational environment and if my child's behavior is in violation of the youth program rules s/he may be dismissed from the program. There is no refund of tuition if my child is expelled.

By signing below, you are authorizing all of the above statements.

Parent/Guardian Printed Name_____ Date_____

Parent/Guardian Signature_____ Date_____