PARENT INFORMATION APPLICATION

Volunteer Internship Program

Volunteer Internship Program "VIP" is a community program that rewards students ages 12-14 with volunteer opportunities that expose them to the world of work.

Who is Eligible?

City of Rochester youth currently enrolled in high school, ages 12-14, who have a minimum of 90% school attendance for the year, and who have not had a long-term (five days or more) suspension during the school year.

Where to Apply?

City of Rochester Youth Service Center
In the Sibley Bldg., 25 Franklin St.,
Second floor, Suite 5B
Rochester, NY 14604
585-428-6342

one city ROCHESTER

Thomas S. Richards, Mayor
City of Rochester, NY

CHILD/FAMILY INFORMATION

To be completed by parent/guardian. Please complete all the information (printing clearly in black or blue ink) and sign where required.

Child's Name: _____

NICKNAME STUDENT ID#

☐ **Male** ☐ **Female** **Birthday** _____

SCHOOL ATTENDING _____

CURRENT GRADE _____ ATTACH A COPY OF MOST RECENT REPORT CARD

City of Rochester youth ages 12-14 must have:

- Minimum 90% school attendance for the year.
- No long term suspensions during the school year.

HOME ADDRESS _____ ZIP _____

HOME TELEPHONE NUMBER ( ) _____ LANGUAGES SPOKEN AT HOME _____

PARENT/GUARDIAN INFORMATION

MOTHER/GUARDIAN NAME _____ FATHER/GUARDIAN NAME _____

ADDRESS _____ ADDRESS _____

HOME PHONE _____ HOME PHONE _____

WORK PHONE _____ WORK PHONE _____

PLACE OF EMPLOYMENT _____ PLACE OF EMPLOYMENT _____

EMERGENCY INFORMATION/CHILD PICK-UP AUTHORIZATION

If my child requires emergency medical care and I cannot be reached, I give my consent to the Volunteer Internship Program to obtain the necessary medical care for my child. I agree to pay all of the costs associated with the emergency medical care that my child receives.

In case of emergency, and the Volunteer Internship Program staff are unable to reach the parent/guardian listed above, the following individuals have permission to pick up my child from the Volunteer Internship Program in case of an emergency or dismissal from the program:

NAME _____ NAME _____

RELATIONSHIP TO CHILD _____ RELATIONSHIP TO CHILD _____

HOME # _____ WORK # _____ HOME # _____ WORK # _____

ADDRESS _____ ADDRESS _____

HEALTH INFORMATION

Indicate YES where it applies and explain as necessary below

Asthma	
Diabetes	
Special Diet	
Convulsions	
Physical Restrictions	
Learning Disabilities	
Allergies	

Hearing	
Vision	
Illness	
Injury	
Psychological / Emotional	
ADD / ADHA	
Other	

Operations	
Hay Fever	
Poison Ivy	
Insect Bite Allergies	
Medication	
Food Allergies	
Other	

PLEASE EXPLAIN ALL YES ANSWERS FROM ABOVE:

_____

_____

_____

_____

_____

_____

_____

IS YOUR CHILD CURRENTLY TAKING PRESCRIBED OR OVER-THE-COUNTER MEDICATION? ☐ YES ☐ NO

IS YOUR CHILD COVERED BY ANY HOSPITALIZATION / MEDICAL CARE POLICY? ☐ YES ☐ NO

Please provide a copy of your hospitalization card. *(A copy can be made by staff for your convenience.)*

MEDICAL DOCTOR _____

ADDRESS _____

PHONE NUMBER _____

CHILD'S PROFILE

The following information will help us to better understand your child and his / her needs.

1. ARE THERE ANY KNOWN SPEECH, HEARING OR VISION DIFFICULTIES?

2. ARE THERE ANY MEDICAL PROBLEMS THAT REQUIRE SPECIAL ATTENTION OR OF WHICH WE SHOULD BE AWARE?

3. DOES YOUR CHILD DISPLAY ANY EMOTIONAL FEARS, BEHAVIOR PROBLEMS OR DIFFICULTIES IN DEALING WITH OTHERS?

4. DOES YOUR CHILD RECEIVE ANY SPECIAL SERVICES THROUGH SCHOOL?

5. IF YOU COULD DESCRIBE YOUR CHILD IN ONE PHRASE, WHAT WOULD IT BE?

6. WHY DO YOU WANT YOUR CHILD IN THIS PROGRAM?

7. ACTIVITIES YOUR CHILD CANNOT PARTICIPATE IN?

8. IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR CHILD?

PARENT/GUARDIAN ARGREEMENT

I, the undersigned, hereby enroll my child, _____

in the Volunteer Internship Program managed by the City of Rochester, Youth Services located in the Sibley Building, 25 Franklin St., 2nd floor, Suite 5B, Rochester, NY 14604. It is understood that the Volunteer Internship Program assumes responsibility for my child's well being during the hours of the program and will make every effort to immediately contact the parent/guardian should any type of emergency arise.

I have provided the staff with pertinent, complete and correct information which may assist the Volunteer Internship Program in caring for my child, including, but not limited to: allergies, previous or existing illnesses or conditions, sunburn sensitivity, diet requirement, long-term medication, disabilities or limiting conditions, emotional development or behavioral difficulties.

The Volunteer Internship Program for my child begins when the child has reached the program and checked in with the Volunteer Internship Program staff person.

It is my responsibility to arrange for my child to be picked up at dismissal time. If my child is not picked up on time and attempts to contact me have failed, another authorized person will be contacted. If all attempts to contact an authorized person to pick up my child have failed, the Volunteer Internship Program will contact Child Protective Services and/or police officials.

I hereby give permission to record the image and/or voice of my child for newsletters, special projects, brochures, web sites or newspaper releases. I understand that I will not be informed or reimbursed for such photographs or videos.

Should a person arrive to pickup my child who appears to be under the influence of drugs or alcohol, for the child's safety, staff may have no recourse but to contact the police.

The Volunteer Internship Program is mandated by state law to report any suspected cases of child abuse or neglect to the appropriate authorities.

My signature acknowledges my understanding of, and agreement to the above and that all information I provide is accurate and complete.

_____

PARENT / GUARDIAN SIGNATURE DATE

_____

PARENT / GUARDIAN NAME PRINTED RELATIONSHIP TO CHILD