Honolulu Community Action Program, Inc.
A Non-Profit Community Action Agency

Hā Initiative:

Creative Science, Technology, Engineering, and Math After-School Program

Participant Information Sheet

Hā Initiative:
Creative Science, Technology, Engineering, and Math (STEM)
After-School Program

Participant Information Sheet

We appreciate you and your child's interest in participating in the Hā Initiative. We have created this information sheet as an effort to ensure a successful and enjoyable experience for your child. All information provided will remain private and confidential.

STEM Classroom:(circle one) **Central** **Kalihi-Palama** **Leeward** **Windward** **Honolulu**
Start Date: _________ (to be completed by STEM teacher)

Participant's Information

First Name: _________________________ Middle Initial:______ Last Name: ____________________________

Date of Birth: ________________ Age: ______ Upcoming Grade AY 20___-20___: ______ Gender: ☐ Male ☐ Female

Name of School: ____

Parent/Guardian Information

First Name: _________________________ Middle Initial:______ Last Name: ____________________________

Relationship to Participant: ____

Address: ____

City: ____ State: _______ Zip: ___________________

Phone: (Home) ____________________ (Work) _______________________ (Other) ________________________

Email: __________________________________ Parents/ Guardians, what language(s) do you speak?____________

Is your child proficient in English? ☐Yes ☐No

Does the student receive free or reduce lunch**?** ☐Yes ☐No

Medical Information (Please complete all 5 questions)

1. My child receives regular care for the following medical conditions: (If none please write N/A.)

____

____

2. Health Insurance: ____
3. Allergies: (If none, please write N/A.)

____

____

4. Requires Epinephrine for allergies? ☐Yes ☐No

5. Is your child taking medications? (Please note Hā Initiative staff and volunteers will not administer medication.)
☐Yes ☐No

6. Does student have special needs or Disabilities? ☐Yes ☐No
If Yes, please specify:____

7. How Did You Hear About Us:

___ Friend or Family member
___ School or Teacher
___ Other: Please Specify ___________________
___ HCAP District Service Center
___ Partner Agency

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Emergency Contact

Full name of Participant: ____

Age of Participant: ____________________ Gender of Participant: ______________________

Preferred Medical Facility: ____

I, **(please print full name)** _______________________________________, parent/guardian of _______________________do hereby authorize the Honolulu Community Action Program (HCAP) and The Ha Initiative: Creative STEM After-School Program to act with limited authority in response to medical and emergency response due to the injury or illness of the participant named above.

I agree to allow the STEM program teacher only to administer basic first aid in event of minor injuries in the classroom (HCAP staff will never administer medication). I authorize that in the event of a medical emergency, defined as life-threatening illness or injury, that the STEM program and HCAP provide and arrange for medical care of the named participant when his/her parent or guardian is not present at the time of acute illness or injury. This will include transportation to a licensed medical facility and allowance for a licensed physician to administer medication, medical care, and necessary treatment for the preservation of the participants' health and well-being. In the event that it is not possible to contact the parent/guardian or listed emergency contacts for instruction, then consent is given to the licensed physician to conduct treatment as deemed necessary for maintaining health and well-being. I understand that any cost incurred for treatment of sudden illness or injury shall be paid by me. This authorization and consent for treatment is given to the STEM program and HCAP in conjunction with any authorized event.

If the parent or primary guardian cannot be reached please call:

Alternate Emergency Contact 1:

Name: ____

Relationship to Participant: ____

Address: ____

City: ____ State: _______ Zip: _______

Phone: (Home) ___________________ (Work) _____________________ (Other) _________

Continue on next page

Alternate Emergency Contact 2:

Name: ____

Relationship to Participant: ____

Address: ____

City: ____ State: _______ Zip: ______

Phone: (Home) ____________________ (Work) ______________________ (Other) ______________

I certify that all information above is true to the best of my knowledge. I release, indemnify, and hold free and harmless HCAP and each of their members, employees, personnel affiliates, and indemnities, from and against any and all actions, claims, liabilities, assertions of liability, losses, expenses including but not limited to medical fees, attorneys' fees, reasonable investigative and discovery costs and court costs, claim or claims for bodily injury or death of persons and for loss of or damage to property, including claims or loss by the indemnities. These provisions will be help exempt to the extent of causation by the gross neglect or willful misconduct of an indemnity. I hold free and harmless the aforementioned which, in any manner, may have arisen or alleged to have arisen, or resulted or alleged to have resulted, from the presence, activities and promotions of any nature whatsoever or otherwise of the undersigned, or affiliates, located on or adjacent to the premises known as the Hā Initiative (HCAP).

Signature of Parent/Guardian____

Date: ____________________

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Media Release Consent Form

I, the undersigned, do hereby authorize Honolulu Community Action Program, Inc. (HCAP) and/or parties other than HCAP (i.e. newspapers, news programming, public broadcasting, etc.) to use any quotes, photographs, digital images, movies, audio/video recordings, biographical information, or academic work in all forms of media, including social media, for the purposes of evaluation, instruction, education, and promotion of HCAP's non-profit services.

I understand there will be no compensation for my time or expenses relating to the terms of this consent.

This consent applies to me and all members in my household.

I understand that my consent can be withdrawn at any time by sending written notification to HCAP's Director of Planning, Program Development & Communications at 1132 Bishop Street, Suite 100, Honolulu, HI 96813-2807

____

Print Name of Participant

____

Print Name of Parent/Guardian (if participant is under 18 years of age)

____ _____________________________

Signature of Participant or Parent/ Guardian Date

____

Name of Center/ Program

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Sign-Out Release Options

Participant's Information

First Name: _________________________ Middle Initial:______ Last Name: ___________________________

Name of School: ____

Check all that apply

_____ My child can sign-out from the program on his/her own and leave without an adult

_____ My child will ride the bus home

_____ My child will walk home

_____ My child may leave the program at any time? Yes or No

_____ Parent pick-up. I need to be there to sign out my child

_____ Sibling Pick-up. An older sibling will sign out my child. List all names of siblings who can pick-up.

Name: ____________________________________ Phone: __________________

Name: ____________________________________ Phone: __________________

Name: ____________________________________ Phone: __________________

_____ Other relative pick-up. List all names of people who can pick-up.

Name: ____________________________________ Phone: __________________

Name: ____________________________________ Phone: __________________

Name: ____________________________________ Phone: __________________

____
Print Name of Parent/Guardian (if participant is under 18 years of age)

____ __________________________
Signature of Participant or Parent/ Guardian Date

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All demographic information will remain private and confidential.

Child Information

1) **Is the Child Disabled:** ☐Yes ☐No

2) **Is the Child Hispanic:** ☐Yes ☐No

3) **Is the Child a COFA Migrant:** ☐Yes ☐No

4) **Race:** (***Check one only***)
☐ African American ☐ American Indian/Alaska Native ☐ Asian ☐ Caucasian
☐ Native Hawaiian ☐ Multi-Race (MR) (two or more races) ☐ Pacific Islander ☐ Other

5) **What type of health insurance does the child have:** (***Check one only***)
☐Medicaid
☐Medicare
☐Quest for Children
☐Direct Purchase
☐Military Health Care
☐Employment Based
☐No Health Care

Family Information

1) **Is the child's parent:** Veteran: ☐Yes ☐No Active Military: ☐Yes ☐No

2) **Household Type:** ***(Check one only)***
☐ Single Person ☐ Two Adults – No Children
☐ Single Parent/ Female ☐ Single Parent/ Male
☐ Multigenerational Household ☐ Two-Parent Household
☐ Non-related Adults with Children ☐ Other

Number of Members in the Household: ________

3) **Housing Information:** ☐ Own ☐ Homeless
(Check one only) ☐ Rent ☐ Other
☐ Other permanent housing

4) **Income Sources:** ***(Check all that apply)***
☐ No Income ☐ Soc. Security
☐ Employment ☐ Soc. Security Disability
☐ Unemployment Insurance ☐ VA Non-Service Disability
☐ Worker's Compensation ☐ VA Service Disability
☐ Pension ☐ Private Disability
☐ Child Support ☐ SSI
☐ Alimony or other spousal support ☐ TANF
☐ Other: ______________________

5) **Benefits:** ***(Check all that apply)***
   - ☐ SNAP
   - ☐ EITC (Earned Income Tax Credit)
   - ☐ WIC
   - ☐ LIHEAP (Low-Income Home Energy Assistance Program)
   - ☐ Housing Choice Voucher (Section 8)
   - ☐ Public Housing
   - ☐ Permanent Supportive Housing (Housing First)
   - ☐ HUD-VASH (VA Homeless Programs)
   - ☐ Childcare Voucher (Childcare Subsidies)
   - ☐ Affordable Care Act Subsidy (Obama Care)
   - ☐ Other income sources Only
   - ☐ Other: ___________________________________

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Release of Information

I, the undersigned, do hereby authorize Honolulu Community Action Program, Inc. (HCAP) to obtain grades and teacher surveys concerning my child from the Hawaii Department of Education, Charter Schools, or Private Schools.

I understand that my consent can be withdrawn at any time by sending written notification to HCAP's Director of Planning, Program Development & Communications at 1132 Bishop Street, Suite 100 Honolulu, HI 96813-2807

____

Print Name of Participant

____

Print Name of Parent/Guardian

____ ____________________________

Signature of Participant or Parent/ Guardian Date

____

Name of Center/ Program

____

Name of School Participant Attends