



**RETURN APPLICATION AND ATTACHMENTS TO:**

AFTER SCHOOL PROGRAM  
LIVING RESOURCES CORPORATION  
300 Washington Ave Ext  
Albany, NY 12203

**QUESTIONS? Please call Kathy Condon at 518-218-0000 ext. 4426**



**LIVING RESOURCES CORPORATION**  
**300 Washington Ave Ext**  
**Albany, NY 12203**  
518-218-0000

AFTER SCHOOL PROGRAM  
APPLICATION

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ SS NO: \_\_\_\_\_

AGE OF STUDENT: \_\_\_\_\_ D.O.B. \_\_\_\_\_ TABS # \_\_\_\_\_

PARENTS/GUARDIANS \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

WORK PHONES \_\_\_\_\_ CELL PHONES \_\_\_\_\_

EMAIL ADDRESSES \_\_\_\_\_

SCHOOL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PHONE NO: \_\_\_\_\_ CLASSROOM TYPE/RATIO: \_\_\_\_\_

TEACHER: \_\_\_\_\_ HOURS ATTENDING PROGRAM: \_\_\_\_\_

SPECIAL SERVICES RECEIVED (OT, PT, and SPEECH):  
\_\_\_\_\_

WHO TRANSPORTS STUDENT TO SCHOOL? \_\_\_\_\_ PHONE NO: \_\_\_\_\_

HOME SCHOOL DISTRICT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

SERVICE COORDINATOR: \_\_\_\_\_ AGENCY: \_\_\_\_\_

PHONE NO: \_\_\_\_\_

DOES YOUR CHILD **HAVE** WAIVER SERVICES?: \_\_\_\_\_  
IN CASE OF EMERGENCY, CONTACT OTHER THAN PARENTS:

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE NO: \_\_\_\_\_

**(NOTE: EMERGENCY CONTACT MUST BE AVAILABLE WHEN PARENTS/GUARDIAN ARE NOT AVAILABLE)**

**MEDICAL INFORMATION**

PHYSICIAN'S NAME: \_\_\_\_\_ PHONE NO: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOSPITAL PREFERRED (IN CASE OF EMERGENCY): \_\_\_\_\_

DATES OF LAST HOSPITAL STAY: \_\_\_\_\_ REASON: \_\_\_\_\_

DATES OF LAST MEDICAL EXAM: \_\_\_\_\_ DENTAL EXAM: \_\_\_\_\_

ALLERGIES:  
\_\_\_\_\_

INSURANCE CO. NAME: \_\_\_\_\_ POLICY NO: \_\_\_\_\_

MEDICAID NO: \_\_\_\_\_ S.S. NO: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

PRIMARY DISABLING CONDITION:  
\_\_\_\_\_  
\_\_\_\_\_

MEDICAL DISABILITIES (I.E. EPILEPSY, SEIZURE DISORDER, CP):  
\_\_\_\_\_  
\_\_\_\_\_

HAS STUDENT RECEIVED THE FOLLOWING IMMUNIZATIONS? (PLEASE CIRCLE):

TETANUS	YES	NO	DATES:
DIPHTHERIA	YES	NO	DATES:
WHOOPING COUGH	YES	NO	DATES:
POLIOMYELITIS	YES	NO	DATES:
RUBELLA	YES	NO	DATES:
MEASLES	YES	NO	DATES:

CURRENT MEDICATIONS:

WHAT IT CONTROLS:

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POSSIBLE SIDE EFFECTS:

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Is applicant able to self-administer medication without supervision?

Is applicant on a special diet?

Is assistance required during eating?

What are favorite foods?

What foods are disliked?

Usual bedtime?

Usual wake up time?

Is he or she physically aggressive towards others?

Is he or she aggressive towards self?

Does he or she interact well with others?

Is he or she destructive of property and materials?

Does he or she have temper tantrums?

Does he or she use obscene language?

How does he or she react when they are frustrated with someone or something?

Is he or she easy to manage in public?

Does he or she need assistance to dress?

Is assistance needed with toileting?

Does he or she indicate need to use the bathroom?

Does he or she walk independently?

If in wheelchair, can he or she transfer independently?

Is he or she verbal? If not, how does he or she communicate? (Gestures, Sign, etc.)?

Is he or she hearing impaired?

Does he or she have preferred activities?

Does he or she follow instructions?

What does he or she do during leisure time?

Does he or she have any fears we should be aware of?

Is there anything you could share with us that would help with your child's participation in the program?

WOULD YOU PLEASE TAKE A MINUTE AND WRITE DOWN A SENTENCE OR TWO ON HOW THIS AFTER SCHOOL PROGRAM WOULD BENEFIT YOUR CHILD AND FAMILY. THANK YOU.

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PLEASE INCLUDE THE FOLLOWING ATTACHMENTS WITH APPLICATION:

1. SIGNED INFORMATION RELEASE (pg. 7)
2. AUTHORIZATION FOR OUTSIDE ACTIVITIES (pg. 8)
3. AUTHORIZATION FOR RELEASE OF PHOTOS (pg.9)
4. Psychological Evaluation (most recent)
5. IEP (most recent)
6. ISP (most recent)

I AUTHORIZE LIVING RESOURCES CORPORATION TO VERIFY ANY AND ALL INFORMATION PROVIDED IN THIS APPLICATION AND ITS ATTACHMENTS:

\_\_\_\_\_  
APPLICANT'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN

\_\_\_\_\_  
DATE

**LIVING RESOURCES CORPORATION**  
**300 Washington Ave Ext.**  
**Albany, NY 12203**

INFORMATION RELEASE

I HEREBY AUTHORIZE \_\_\_\_\_ SCHOOL DISTRICT TO  
RELEASE THE FOLLOWING RECORDS/INFORMATION TO LIVING RESOURCES:

Most recent psychological evaluation or update

Most recent I.E.P. including social goals

If applicable, adaptive contracts

I UNDERSTAND THAT ALL INFORMATION NAMED IN THIS RELEASE WILL BE KEPT  
CONFIDENTIAL AND WILL BE USED ONLY IN MY SON'S/DAUGHTER'S BEST INTEREST.

I AUTHORIZE A COPY OF THIS SIGNED AUTHORIZATION TO BE EXECUTED WITH THE SAME  
AUTHORITY AS THE ORIGINAL.

I GIVE PERMISSION FOR A REPRESENTATIVE OF LIVING RESOURCES AFTER SCHOOL  
PROGRAM TO VISIT MY SON/DAUGHTER, \_\_\_\_\_, AT  
HIS/HER SCHOOL PROGRAM REGARDING PLACEMENT IN THE AFTER SCHOOL PROGRAM.

SIGNED: \_\_\_\_\_

DATE: \_\_\_\_\_

FOR: \_\_\_\_\_

D.O.B. \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

S. S. # \_\_\_\_\_

**LIVING RESOURCES CORPORATION AFTER SCHOOL PROGRAM**

Authorization For Outside Activities

I understand that Living Resources' After School Program offers regular opportunities for community activities which include, but are not limited to visits to local parks, recreational areas, museums, shopping malls, and theaters. When weather permits, outside activities may occur several times weekly.

I hereby authorize the staff of Living Resources Corporation to transport my son/daughter,  
\_\_\_\_\_, to and from any of the outside activities participated in by the  
After School Program.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date



**Living Resources Corporation**

300 Washington Ave Ext  
Albany, NY 12203  
Phone (518) 218-0000  
Fax (518) 862-2175

**Informed Consent To Use Consumer Pictures For Agency Publicity**  
For Events Which Are Expected To Have Media Coverage

Living Resources often develops pamphlets, videos, brochures, slide shows, photo displays, as well as the website information page etc. to explain the agency programs and to encourage people to support the agency. These materials are shown or distributed to the general public.

There are also times when radio, television, and/or newspapers will be present at some of Living Resources' events.

Please indicate below whether you would or would not like yourself or your son/daughter to participate in Living Resources' publicity-related materials or events.

I, \_\_\_\_\_, give permission\*  
(print name)

**Agency Publications**

To have my photograph taken or voice recorded for Living Resources publicity materials (website, brochures, slide show videos, etc.)

**Media Coverage**

To take part in media coverage (website, radio, television and/or newspapers) for Living Resources' related events.

I release Living Resources, its agents and employees, including broadcast and print media from any liability to me for invasion of privacy under law.

I, \_\_\_\_\_ do not wish to participate in any of Living Resources' publicity-related events.  
(print name)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\*Living Resources will make every effort to notify you of each event before it takes place.

**Publicity Consent Expiration Upon Discharge**



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