2025-2026 School Year
West Side Kids After-School Child Care Registration

Dear Families,
Thank you for choosing West Side Community Services' West Side Kids After-School Program to support your child's growth!

West Side Kids is available to children in kindergarten through sixth grade enrolled in Buffalo Public and charter schools. We are open Monday through Friday, 2:30–6:00 p.m. The program begins Thursday, September 4, 2025.

West Side Kids follows the **Buffalo Public Schools (BPS) calendar**. If BPS is closed due to a holiday, weather emergency, or cancels after-school programs, **West Side Kids will also be closed**.

Exception: We typically remain open during **Winter Break Camp** in February.

Our program is licensed by the New York State Office of Children and Family Services. Your child will receive a meal, snack, academic support, physical activity, and creative enrichment.

We partner with the Erie County Department of Social Services to offer affordable childcare. We will help you complete the necessary paperwork for financial assistance, and WSCS offers need-based support to ensure all children can participate.

Please review the attached information and return the completed registration forms to secure your child's spot.

Questions? We're here to help!
Call us at **716-884-6616** and ask for:

- **Fatima Elabed**, Youth Site Coordinator
  Ext. 103 | felabed@wscsbuffalo.org
- **Marino Frias**, Director of Youth Programs
  Ext. 104 | mfrias@wscsbuffalo.org

Sincerely,
Marino Frias, Director of Youth Programs

Child's Full Name: _____

Child's Grade: _____

Child's School: _____

Please select all that apply to your child:

☐ **Attended 2024-2025 after-school program** ☐ **Attended 2025 summer camp**

West Side Community Services

Program Fees

West Side Kids charges a fee of $240 per child per month billed monthly. We are committed to ensuring that West Side Kids fits into your family's budget. We work with the Erie County Department of Social Services to provide an efficient application process to the Child Care Assistance Program. We also provide scholarship opportunities for families who may not qualify for the Child Care Assistance Program, but still require financial assistance. (A payment schedule is below; please feel free to reference throughout the year.)

Payment Due Dates	Payment amount (non DSS)	Payment amount (DSS)	Scholarship
9/5/2025	$240.00 per child	Parent fee based on agreement with DSS	N/A
10/5/2025	$240.00 per child	Parent fee based on agreement with DSS	Requires 90% attendance
11/5/2025	$240.00 per child	Parent fee based on agreement with DSS	Requires 90% attendance
12/5/2025	$240.00 per child	Parent fee based on agreement with DSS	Requires 90% attendance
1/5/2026	$240.00 per child	Parent fee based on agreement with DSS	Requires 90% attendance
2/5/2026	$240.00 per child	Parent fee based on agreement with DSS	Requires 90% attendance
3/5/2026	$240.00 per child	Parent fee based on agreement with DSS	Requires 90% attendance
4/5/2026	$240.00 per child	Parent fee based on agreement with DSS	Requires 90% attendance
5/5/2026	$240.00 per child	Parent fee based on agreement with DSS	Requires 90% attendance
6/5/2026	$240.00 per child	Parent fee based on agreement with DSS	Requires 90% attendance

* Parent/Guardian must make payments at the time of registration or drop into the office during open hours to submit a payment throughout the school year. You may also pay by credit card at wscsbuffalo.org/feepayment or mail a check (made out to West Side Community Services) to 161 Vermont Street, Buffalo, NY 14213.

West Side Kids Scholarship Process & Reduced Fee Program

West Side Community Services is committed to making the West Side Kids program accessible to all families. We currently accept the following forms of payment:

1. **Erie County Child Care Assistance**
    - *Please note: Families approved for this assistance are responsible for a required parent contribution, as determined by Erie County.*
2. **A WSCS Scholarship** (based on a sliding scale determined by household income)
3. **Direct Pay at the full program rate**

If your family applies for Erie County Child Care Assistance and is **denied for a reason other than financial eligibility**, you may qualify for a **WSCS Scholarship**. This scholarship is based on **household income** and aligned with federal income guidelines.

Please note: If your family's income is **too high to qualify for both DSS Child Care Assistance and the WSCS Scholarship**, you will not be eligible for financial aid and must pay the **standard program rate** through direct pay.

Sliding Scale Scholarship Rates

- Families earning **up to 80% of the Area Median Income (AMI)** may qualify for a **reduced rate of $140/month.**
- Families earning **up to 50% of the AMI** may qualify for a **further reduced rate of $60/month.**
- Eligibility for sliding scale scholarships is based on **completion of the CDBG Client Characteristics Form, which is located at the back of every afterschool application.**
- We are committed to working with families—**regardless of financial situation**—to ensure access to safe, high-quality childcare. Please contact us if you have any questions.

How to Apply for a Scholarship

To be considered for a WSCS Scholarship, families must submit:

1. A **recent rejection letter** from the **Erie County Department of Social Services Day Care Unit**, indicating denial for reasons **other than financial eligibility.**
2. A completed **CDBG Client Characteristics Form** (found at the back of the after-school application).
3. **At least 2 recent paystubs** or your **most recent tax return** as proof of income.
    - Additional documentation may be requested if needed.

Ongoing Scholarship Requirements

To maintain scholarship eligibility:

- **Scholarship applications must be renewed each school year** and must include a new DSS rejection letter.
- Children must maintain **at least 90% attendance** in the West Side Kids program.

If you have any questions or concerns about the scholarship process or payment options, please contact:

Marino Frias
Director of Youth Programs
Phone: 716-884-6616 ext. 104
Email: mfrias@wscsbuffalo.org

West Side Community Services

Attendance Policy

We understand that life happens, and occasional absences are sometimes unavoidable. We simply ask for transparency and communication regarding your child's attendance.

If you know in advance that your child will miss one or more days of **West Side Kids**, please notify the **front desk staff**, **Site Coordinator**, or the **Director of Youth Programs** as soon as possible.

If your child is out due to an unexpected illness, the absence will be counted as **excused**, as long as you call the office that day to let us know.

What is an unexcused absence?
An unexcused absence is when a child does not attend the program **without prior notice** and **without communication on the day of the absence.**

Attendance Policy Reminder:
Children are allowed up to **5 unexcused absences per school year**. After the fifth unexcused absence, your child may **lose their spot** in the program to make room for another family on the waitlist.

Thank you for helping us keep West Side Kids running smoothly and fairly for all families.

I understand and will abide by WSCS's attendance policy for the 2025-2026 West Side Kids After-School Child Care Program.

Parent/Caregiver name (print): _____

Parent/Caregiver signature: _____

Date: _____ School Bus Number (if known): _____

Late Pick-up Policy

The West Side Community Services after-school program is open until 6 p.m. on school days. All children who participate in the program must be picked up by this time.

The late pick-up fee structure is as follows:

1. $10 late fee for pick-ups between 6:01 and 6:15 p.m.

2. An additional $1 will be added per minute after 6:15 p.m.

Frequent late pick-ups may result in suspension and/or dismissal from the program. Fifteen minutes after scheduled center closure, all emergency numbers will be called by staff. If no one can be reached by 7:00 p.m., WSCS staff reserve the right to contact the police to escort your child(ren) to Protective Services for child abandonment. Please note, the staff will do everything in their power to contact emergency numbers. Calling the police will be a very last resort. This must be our policy to protect both staff and children.

Late fee payments need to be made within seven (7) days from the late pick-up day. Failure to make payments may result in longer program suspensions and/or dismissal from West Side Kids After-School Child Care Program.

Please contact us for additional information, questions, or concerns.

Thank you for your continued partnership in creating a safe and nurturing after-school childcare program at West Side Community Services.

Sincerely,
Marino Frias
Director, Youth Department

I understand and agree to abide by West Side Community Services' late pick-up fee policy for my child(ren).

Parent/Caregiver name (print): _____

Parent/Caregiver signature: _____

Date: _____

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DAY CARE ENROLLMENT

PHOTO OF CHILD (Optional)

PROGRAM NAME:	ADDRESS:	PHONE NUMBER:
West Side Community Services, Inc.	161 Vermont Street, Buffalo, NY 14213	716-884-6616

CHILD'S FULL NAME:
PREFERRED NAME/NICKNAME:
DATE OF BIRTH:
GENDER:

CHILD'S HOME ADDRESS:

NAME OF PERSON ENROLLING CHILD:

RELATIONSHIP TO CHILD:
☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative _____
☐ Other _____

PHONE NUMBER(S) OF PERSON ENROLLING CHILD:
☐ ok to text

EMAIL ADDRESS:

ADDRESS OF PERSON ENROLLING CHILD (IF DIFFERENT THAN CHILD):

EMERGENCY INFO

EMERGENCY CONTACT NAMES / ADDRESSES	Authorized to Pick Up Child	PRIMARY PHONE NUMBER	OTHER PHONE NUMBER / EMAIL
PRIMARY CONTACT:	☐ Yes ☐ No	☐ ok to text	☐ ok to text
	☐ Yes ☐ No	☐ ok to text	☐ ok to text
	☐ Yes ☐ No	☐ ok to text	☐ ok to text

FOR PROGRAM USE ONLY
DATE OF ENROLLMENT: / /

FOR PROGRAM USE ONLY
DATE OF DISENROLLMENT: / /

CHILD'S FULL NAME:
DATE OF BIRTH:

Check boxes below to indicate if your child has any special needs/services: ☐ None

☐ Early Intervention/Special Education ☐ Occupational Therapy ☐ Speech/Language ☐ Physical Therapy

☐ Allergies (Please list) _____

☐ Other _____

Please provide information here **AND** discuss with your child care provider:

CHILD'S PRIMARY CARE PHYSICIAN'S NAME/ GROUP:	PHONE NUMBER:
PREFERRED HOSPITAL:	PHONE NUMBER:
CHILD'S DENTAL CARE:	PHONE NUMBER:

Child health care information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: https://nystateofhealth.ny.gov/

AGREEMENTS

- I consent to emergency medical treatment for my child…… ☐ Yes ☐ No
- I consent for my child to take part in neighborhood trips (i.e., library, park and playground) away from the program under proper supervision…… ☐ Yes ☐ No
- I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips…… ☐ Yes ☐ No
- I provided information on my child's special needs to the program to assist in caring for my child…… ☐ Yes ☐ No
- I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation…… ☐ Yes ☐ No
- I agree to review and update this information whenever a change occurs and at least once every year…… ☐ Yes ☐ No

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:	DATE:

West Side Community Services

Pick-Up Procedure

Parents/guardians/family members must come into West Side Community Services to pick up their child from the After-School Child Care Program.

Please list below the individuals authorized to pick up your child. ***These individuals (including you!) must bring a valid photo ID in order for a West Side Community Services staff member to release your child to their care.***

First & Last Name	Phone Number	Address	Relationship to Child

Do you give permission for your child to walk or ride their bike home from West Side Community Services at 5:30 PM?

- ◯ Yes
- ◯ No

Does your child have any current orders of protection regarding their safety? (Please check one):

- ◯ NO, my child **does not** have any current orders of protection regarding their safety.
- ◯ YES, my child **does** have a related order of protection regarding their safety.
  If YES - please provide copies of current orders of protection that relate to your child. These documents must include a clear photo, full name, and license/make/model of vehicle for anyone named in the order and all persons not allowed to be near your child.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician Assistant or Nurse Practitioner

Name of Child:	Date of Birth: / /	Date of Examination: / /

Immunizations required for entry into day care

Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s). ☐ Yes ☐ No

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	5th Date / /
Polio (IPV or OPV)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Haemophilus influenzae type B (Hib)	1st Date / /	2nd Date / /	3rd Date / /	4th Date **OR** 1st Date (if given on or after 15 months of age) / /	
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Hepatitis B	1st Date / /	2nd Date / /	3rd Date / /		
Measles, Mumps and Rubella (MMR)	1st Date / /	2nd Date / /			
Varicella (also known as Chicken Pox)	1st Date / /	2nd Date / /			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date: / /	Type of Immunization:	Date: / /
Type of Immunization:	Date: / /	Type of Immunization:	Date: / /
Type of Immunization:	Date: / /	Type of Immunization:	Date: / /

Tests

Tuberculin Test Date: / / Mantoux Results: ☐ Positive ☐ Negative _____ mm

TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: / /

Attach lead level statement

Lead Screening (Include All Dates and Results)

1 year / / Result: _____ mcg/dL ☐ Venous ☐ Capillary

2 years / / Result: _____ mcg/dL ☐ Venous ☐ Capillary

Most recent date of lead screening (if different from above):

/ / Result: _____ mcg/dL ☐ Venous ☐ Capillary

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely. If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

(Continued on reverse side)

CHILD IN CARE MEDICAL STATEMENT *(continued)*

Health Specifics		Comments
Are there allergies? (Specify)	☐ Yes ☐ No	
Is medication regularly taken? (Specify drug and condition)	☐ Yes ☐ No	
Is a special diet required? (Specify diet and condition)	☐ Yes ☐ No	
Are there any hearing, visual or dental conditions requiring special attention?	☐ Yes ☐ No	
Are there any medical or developmental conditions requiring special attention?	☐ Yes ☐ No	

Summary of Physical Exam

Include special recommendations to child day care providers

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care. ☐ Yes ☐ No

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

( ) - Phone

/ / Date

West Side Community Services

Does your child require any medications to be administered after school? (Please note that our staff are not permitted to administer or supervise self-administration of medications to children. If your child requires after-school medication, please contact the office to discuss options.):

- ◯ No
- ◯ Yes

(If you check 'yes,' a note is required from the prescribing physician.)

Medication Name	Dosage	Time(s) Given

I give permission for my child to apply sunscreen on themself.

- ◯ Yes
- ◯ No

I give permission for my child to self-administer their **INHALER**.

- ◯ Yes (must complete OCFS forms 7006 and 7002)
- ◯ No
- ◯ Not applicable (does not use an inhaler).

I acknowledge that my child can self-administer their **EPIPEN** as prescribed by physician.

- ◯ Yes (must complete OCFS forms 7006, 7002, and 6029)
- ◯ No (skip OCFS 6029)
- ◯ Not applicable (does not use an EpiPen).

Does your child have any special heath care needs? (A child with a special health care need has a chronic physical, developmental, behavioral, or emotional condition expected to last 12 months or more and who requires health and related services of a type or amount beyond that required by children generally.)

- ◯ Yes (if yes, you must complete next 2 pages with child's physician– OCFS-LDSS-7006)
- ◯ No (if no, skip next 2 pages)

My child has permission to engage in all after-school activities except as noted. The information provided on this form is accurate to the best of my knowledge. I have indicated any special health conditions, including required medication and activity limitations. I give consent in advance of medical treatment at an appropriate facility in case of illness or injury.

Parent/Guardian Printed Name:_____

Parent/Guardian Signature:_____ Date:_____

If your child has no special health care needs, does not use an EpiPen, does not use an inhaler, AND does not require medications to be administered after school, skip to page 18 (Supplemental Info).

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

You may use this form or an approved equivalent to document an individual health care plan developed for a child with special health care needs.

A child with a special health care need means a child who has a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and who requires health and related services of a type or amount beyond that required by children generally.

Working in collaboration with the child's parent and child's health care provider, the program has developed the following health care plan to meet the individual needs of:

CHILD NAME:	CHILD DATE OF BIRTH: / /
NAME OF THE CHILD'S HEALTH CARE PROVIDER:	☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner

Describe the special health care needs of this child and the plan of care as identified by the parent and the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment.

Identify the caregiver(s) who will provide care to this child with special health care needs:

Caregiver's Name	Credentials or Professional License Information (if applicable)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

Describe any additional training, procedures or competencies the caregiver identified will need to carry out the health care plan for the child with special health care needs as identified by the child's parent and/or the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment. In addition, describe how this additional training and competency will be achieved including who will provide this training.

This plan was developed in close collaboration with the child's parent and the child's health care provider. The caregivers identified to provide all treatments and administer medication to the child listed in the specialized individual health care plan are familiar with the child care regulations and have received any additional training needed and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

PROGRAM NAME:	FACILITY ID NUMBER:	PROGRAM TELEPHONE NUMBER:
West Side Community Services, Inc.	871144	(716) 884-6616
CHILD CARE PROVIDER'S NAME (PLEASE PRINT):		DATE: / /
CHILD CARE PROVIDER'S SIGNATURE: **X**		

I agree this Individual Health Care Plan meets the needs of my child. Yes ◯ No ◯

I give consent to share information about my child's allergy with all program caregivers in a non-discreet way. I support the strategies the program implements to keep my child from being exposed to known allergen(s). I acknowledge these strategies may include visual reminders that may result in the disclosure of my child's confidential allergy information to non-child care staff. Yes ◯ No ◯

Signature of Parent:

X	DATE: / /

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICATION CONSENT FORM

CHILD DAY CARE PROGRAMS

- This form may be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays.
- Only those staff certified to administer medications to day care children are permitted to do so.
- One form must be completed for each medication. Multiple medications cannot be listed on one form.
- Consent forms must be reauthorized at least once every six months for children under 5 years of age and at least once every 12 months for children 5 years of age and older.

LICENSED AUTHORIZED PRESCRIBER COMPLETE THIS SECTION (#1 - #18) AND AS NEEDED (#33 - 35).

1. Child's First and Last Name:	2. Date of Birth: / /	3. Child's Known Allergies:
4. Name of Medication *(including strength):*	5. Amount/Dosage to be Given:	6. Route of Administration:

7A. Frequency to be administered: _____

OR

7B. Identify the symptoms that will necessitate administration of medication: *(signs and symptoms must be observable and, when possible, measurable parameters)*: _____

8A. Possible side effects: ☐ See package insert for complete list of possible side effects *(parent must supply)*

AND/OR

8B: Additional side effects:

9. What action should the child care provider take if side effects are noted:

☐ Contact parent ☐ Contact health care provider at phone number provided below

☐ Other *(describe):* _____

10A. Special instructions: ☐ See package insert for complete list of special instructions *(parent must supply)*

AND/OR

10B. Additional special instructions: *(Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situation's when medication should not be administered.)* _____

11. Reason for medication *(unless confidential by law)*: _____

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and requires health and related services of a type or amount beyond that required by children generally?

☐ No ☐ Yes If you checked yes, complete (#33 and #35) on the back of this form.

13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered?

☐ No ☐ Yes If you checked yes, complete (#34 -#35) on the back of this form.

14. Date Health Care Provider Authorized: / /	15. Date to be Discontinued or Length of Time in Days to be Given: / /
16. Licensed Authorized Prescriber's Name (please print):	17. Licensed Authorized Prescriber's Telephone Number:

18. Licensed Authorized Prescriber's Signature:

X

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICATION CONSENT FORM

CHILD DAY CARE PROGRAMS

PARENT COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? *(For example, did the licensed authorized prescriber write 12pm?)* ◯ Yes ◯ N/A ◯ No

Write the specific time(s) the child day care program is to administer the medication *(i.e.: 12 pm*): _____

20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to *(child's name):*

21. Parent's Name *(please print)*:	22. Date Authorized:

23. Parent's Signature:

X

CHILD DAY CARE PROGRAM COMPLETE THIS SECTION (#24 - #30)

24. Program Name:	25. Facility ID Number:	26. Program Telephone Number:

27. I have verified that (#1 - #23) and if applicable,(#33 - #36) are complete. My signature indicates that all information needed to give this medication has been given to the day care program.

28. Staff's Name *(please print)*:	29. Date Received from Parent: / /

30. Staff Signature:

X

ONLY COMPLETE THIS SECTION (#31 - #32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN (#15)

31. I, parent, request that the medication indicated on this consent form be discontinued on **/ /**
(Date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent Signature:

X

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #35)

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.

34. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date you are ordering the change in the administration of the prescription to take place.

DATE: / /

By completing this section, the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

35. Licensed Authorized Prescriber's Signature:

X

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL ALLERGY AND ANAPHYLAXIS EMERGENCY PLAN

Instructions:

- This form is to be completed for any child with a known allergy.
- The child care program must work with the parent(s)/guardian(s) and the child's health care provider to develop written instructions outlining what the child is allergic to and the prevention strategies and steps that must be taken if the child is exposed to a known allergen or is showing symptoms of exposure.
- This plan must be reviewed upon admission, annually thereafter, and anytime there are staff or volunteer changes, and/or anytime information regarding the child's allergy or treatment changes. This document must be attached to the child's Individual Health Care Plan.
- Add additional sheets if additional documentation or instruction is necessary.

Child's Name: Date of Plan: / /

Date of Birth: / / Current Weight: lbs.

Asthma: ◯ Yes (higher risk for reaction) ◯ No

My child is reactive to the following allergens:

Allergen:	**Type of Exposure**: (***i.e.***, ***air/skin contact/ingestion, etc.***):	**Symptoms include but are not limited to:** (***check all that apply***)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)

If my child was LIKELY exposed to an allergen, for ANY symptoms:

☐ give epinephrine immediately

If my child was DEFINITELY exposed to an allergen, even if no symptoms are present:

☐ give epinephrine immediately

Date of Plan: / /

THE FOLLOWING STEPS WILL BE TAKEN IF THE CHILD EXHIBITS SYMPTOMS including, but not limited to:

- **Inject epinephrine immediately and note the time when the first dose is given**.
- **Call 911/local rescue squad** (Advise 911 the child is in anaphylaxis and may need epinephrine when emergency responders arrive).
- Lay the person flat, raise legs, and keep warm. If breathing is difficult or the child is vomiting, allow them to sit up or lie on their side.
- If symptoms do not improve, or symptoms return, an additional dose of epinephrine can be given in consultation with 911/emergency medical technicians.
- Alert the child's parents/guardians and emergency contacts.
- After the needs of the child and all others in care have been met, immediately notify the office.

MEDICATION/DOSES

- Epinephrine brand or generic:
- Epinephrine dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

ADMINISTRATION AND SAFETY INFORMATION FOR EPINEPHRINE AUTO-INJECTORS

When administering an epinephrine auto-injector follow these guidelines:

- Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than the mid-outer thigh. If a staff member is accidentally injected, they should seek medical attention at the nearest emergency room.
- If administering an auto-injector to a young child, hold their leg firmly in place before and during injection to prevent injuries.
- Epinephrine can be injected through clothing if needed.
- Call 911 immediately after injection.

STORAGE OF EPINEPHRINE AUTO-INJECTORS

- All medication will be kept in its original labeled container.
- Medication must be kept in a clean area that is inaccessible to children.
- All staff must have an awareness of where the child's medication is stored.
- Note any medications, such as epinephrine auto-injectors, that may be stored in a different area.
- Explain here where medication will be stored:

MAT/EMAT CERTIFIED PROGRAMS ONLY

Only staff listed in the program's Health Care Plan as medication administrant(s) can administer the following medications. Staff must be at least 18 years old and have first aid and CPR certificates that cover all ages of children in care.

- Antihistamine brand or generic:
- Antihistamine dose:
- Other (e.g., inhaler-bronchodilator if wheezing):

***Note: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

STORAGE OF INHALERS, ANTIHISTAMINES, BRONCHODILATOR

All medication will be kept in its original labeled container. Medication must be kept in a clean area that is inaccessible to children. All staff must have an awareness of where the child's medication is stored. Explain where medication will be stored. Note any medications, such as asthma inhalers, that may be stored in a different area.

Explain here:

STRATEGIES TO REDUCE THE RISK OF EXPOSURE TO ALLERGIC TRIGGERS

The following strategies will be taken by the child care program to minimize the risk of exposure to any allergens while the above-named child is in care (add additional sheets if needed):

Document plan here:

EMERGENCY CONTACTS – CALL 911	
Ambulance: ( ) -	
Child's Health Care Provider:	Phone #: ( ) -
Parent/Guardian:	Phone #: ( ) -
CHILD'S EMERGENCY CONTACTS	
Name/Relationship:	Phone#: ( ) -
Name/Relationship:	Phone#: ( ) -
Name/Relationship:	Phone#: ( ) -

Parent/Guardian Authorization Signature:	Date: / /
Physician/HCP Authorization Signature:	Date: / /
Program Authorization Signature:	Date: / /

West Side Community Services

West Side Kids – Supplemental Info Form

Supplemental Information Form (please complete with your child)
Help us get to know your child so we can make their after-school experience safe, fun, and engaging!

Child's Name (Preferred): _____
Grade (2025–2026): _____
School: _____

🧠 About Your Child

Personality (check all that apply):
☐ Outgoing ☐ Shy ☐ Energetic ☐ Creative ☐ Sensitive ☐ Independent ☐ Needs support
Interests (check all that apply):
☐ Sports ☐ Art ☐ Music ☐ Reading ☐ Building ☐ Games ☐ Quiet play
Other:
Excited by:
☐ Friends ☐ New things ☐ Hands-on projects ☐ Active games ☐ Rewards ☐ Chill time

💬 Social & Emotional Needs

Around other kids:
☐ Makes friends ☐ Plays alone ☐ Needs help joining in ☐ Leads ☐ Struggles with conflict
Challenges?
☐ Focus ☐ Frustration ☐ Anxiety ☐ Change ☐ Sensory needs ☐ None
Other:
What helps calm them?
☐ Quiet space ☐ Talking ☐ Moving ☐ Alone time ☐ Breathing
Other:

🚀 Motivation

What motivates them?
☐ Praise ☐ Rewards ☐ Leadership ☐ Adult attention ☐ Fun ☐ Competition
What helps them stay engaged?
☐ Choices ☐ Positive feedback ☐ Breaks ☐ Buddy ☐ Hands-on

🧰 After-School History

Attended after-school before? ◯ Yes ◯ No
Positive experience? ◯ Yes ◯ No
If no, why?

Anything else we should know:

_____

West Side Community Services

COVID-19 RELEASE AND WAIVER OF CLAIMS ADDENDUM

The undersigned, in my capacity as parent or legal guardian, hereby acknowledges the health risks and dangers associated with the transmission of the COVID-19 virus, and other communicable diseases, and recognizes that exposure to the COVID-19 virus, or other communicable diseases, could occur while in the care of West Side Community Services.

As such, and in consideration for child care services to be provided by West Side Community Services, the undersigned, for myself and my minor children enrolled in the program fully assume all of the risks associated with participation in the program, including the possibility of COVID-19 (or the novel coronavirus) community spread.

I, AS PARENT AND/OR LEGAL GUARDIAN, HAVE READ AND FULLY UNDERSTAND AND ACKNOWLEDGE THE CONTENTS OF THE RELEASE AND AGREE THAT I AM VOLUNTARILY WAIVING, RELEASING, INDEMNIFYING, AND DISCHARGING WEST SIDE COMMUNITY SERVICES AND ITS OFFICERS, DIRECTORS, EMPLOYEES, AND VOLUNTEERS FROM ANY AND ALL LIABILITY, DAMAGES, AND EACH AND EVERY ACTION (COLLECTIVELY, “CLAIMS”) BY PARTICIPATION IN AND/OR ASSOCIATED WITH THE PROGRAM INCLUDING, BUT NOT LIMITED TO EXPOSURE OR TRANSMISSION OF THE COVID-19 VIRUS.

I represent that I have full authority to sign on behalf of my child and that my signature binds each other person having authority to make decisions on behalf of the child.

MY SIGNATURE BELOW IS CONFIRMATION THAT I HAVE READ AND FULLY UNDERSTAND AND ACKNOWLEDGE THE CONTENTS OF THE RELEASE AND AGREE THAT I AM VOLUNTARILY WAIVING, RELEASING, INDEMNIFYING AND DISCHARGING WEST SIDE COMMUNITY SERVICES AND ITS DIRECTORS, EMPLOYEES, AND VOLUNTEERS FROM THE CLAIMS.

Parent/Guardian Name (print)_____

Parent/Guardian Signature_____

Child’s Name_____

Date _____

West Side Community Services

Code of Conduct

West Side Community Services believes that all children have a right to a safe and healthy environment. West Side Community Services has an obligation to promote mutual respect, tolerance, and acceptance.

Child Expectations:

- Follow all directions given by West Side Community Services staff
- Respect one another
- Include each other
- Create a welcoming community

West Side Community Services will not tolerate behavior that infringes on the safety of any child. A child shall not intimidate, harass, or bully another child through words or actions. Such behavior includes: direct physical contact, such as hitting or shoving; verbal assaults, such as teasing or name-calling; and social isolation or manipulation.

Physical, Verbal, or Emotional Bullying:

- A phone call home will be made after any physical incident.
- After a second infraction on the same day, the child will be sent home immediately and receive a one-day suspension from the program.
- After three suspensions, the child will be removed from the program.

Sexual Harassment:

- A phone call home will be made, immediate pick-up of the child, and a two-day suspension is enforced.
- After two suspensions the child will be removed from the program.
- Sexual harassment includes, but is not limited to, inappropriate touching, unwanted comments, and staring.

My child and I agree to help build a positive community and understand the behavior policy.

Parent Signature: _____

Parent Committee

We work directly with parents to improve our services, plan fun events, and navigate challenges. We meet approximately every other month and help to put on several events per year. If you are interested in joining the parent committee, please indicate the days/times you would prefer to meet below.

◯ I am interested! My preferred meeting days/times are: _____

◯ I am not interested in joining the parent committee. (You are welcome to join later if you change your mind!)

West Side Community Services

Other Authorizations

Participation

I give permission for my child to participate in all activities, including but not limited to evidence-based prevention programming, sports activities, arts and culture activities, and field trips, and to be transported as authorized by WSCS if applicable. If field trip locations are close, we will walk to these places. I understand that I will be notified in advance of any field trips. I release from liability, recognizing that West Side Community Services will do its best to ensure a safe experience. I understand that accidents may occur both from my child's participation in program activities and from transportation to and from the program. I agree to assume these risks.

Media

I understand that my child may be photographed during normal hours, field trips, or activities. I understand that these photographs may be used in promoting childcare services, either in print or digital formats. I understand that it is my responsibility to update this form in the event that I no longer wish to authorize the above uses. I agree that this will remain in effect during the term of my child's enrollment. I understand that there will be no payment for me or my child's participation in this release.

- ◯ YES, it is ok to take photos of my child and use them in print and digital formats.
- ◯ NO, it is not ok to take photos of my child.

_____

(Parent/Caregiver Signature) Date

If your child has a SEVERE food allergy or medical condition or if there is anything not covered in this application that you would like to discuss with us, please contact our office directly to meet about your child's needs.

Please return completed registration packet to:
Fatima Elabed, Youth Site Coordinator/Prevention Manager
Or
Marino Frias, Director, Youth Department

West Side Community Services
161 Vermont Street, Buffalo, NY 14213

Agency: _____
Activity: _____

CLIENT CHARACTERISTIC FORM - CDBG 50

Public Services - Limited Clientele Activities

Staff Reviewed Initial _____
Issue Date: **10/1/24**
IL Revision Date: 6/1/25

PARTICIPANTS MUST FILL AND COMPLETE ENTIRE FORM FOR ELIGIBILITY. THIS INFORMATION IS FOR RECORD KEEPING ONLY AND WILL NOT BE PUBLICLY SHARED.

Home Address: _____ City: _____ Zip: _____

1. Individual Age: Please check **one** from the below based on your (the participant) age.

◯ Under 5 years	◯ 10-15 years	◯ 21-24 years	◯ 45-54 years	◯ 62 years and older
◯ 5-9 years	◯ 16-20 years	◯ 25-44 years	◯ 55-61 years	

2. Gender: Please check **one** from the below based on your (the participant) gender.

◯ Male	◯ Female	◯ Other: _____

3. Please check **one** from the below for your (the participant) ethnicity. Ethnicity and Race are separate, please answer #4 as well.

◯ Hispanic	◯ Non-Hispanic

4. Please check **one** from the below which best describes your (the participant) race.

◯ White	◯ Asian and Black or African American
◯ Black or African American	◯ American Indian or Alaskan Native and White
◯ Asian	◯ American Indian or Alaskan Native and Black or African American
◯ American Indian or Alaskan Native	◯ Native Hawaiian or other Pacific Islander and White
◯ Native Hawaiian or other Pacific Islander	◯ Native Hawaiian or other Pacific Islander and Black or African American
◯ Black or African American and White	◯ Other/Multi Racial
◯ Asian and White	

5. Is your (the participant) family type defined as an **adult female head of household** (no male significant other with dependents)?

◯ Yes	◯ No	◯ Not Applicable

6. Are you (the participant) severely disabled?

◯ Yes	◯ No

7. Household Income: Please check **one** from the below based on your income and the number of members living in your household. **You may skip this section if you are over the age of 62, severely disabled or meet any other criteria for Presumed Benefit.**

Income Limits	1 Person Household	2 Person Household	3 Person Household	4 Person Household
30% median (XL)	◯ $21,250 or less	◯ $24,250 or less	◯ $27,300 or less	◯ $32,150 or less
50% median (VL)	◯ $35,350 or less	◯ $40,400 or less	◯ $45,450 or less	◯ $50,500 or less
80% median (LI)	◯ $56,600 or less	◯ $64,650 or less	◯ $72,750 or less	◯ $80,800 or less
81%+ median	◯ $56,601 or more	◯ $64,651 or more	◯ $72,751 or more	◯ $80,801 or more
Income Limits	**5 Person Household**	**6 Person Household**	**7 Person Household**	**8 Person Household**
30% median (XL)	◯ $37,650 or less	◯ $43,150 or less	◯ $48,650 or less	◯ $54,150 or less
50% median (VL)	◯ $52,350 or less	◯ $58,600 or less	◯ $62,650 or less	◯ $66,700 or less
80% median (LI)	◯ $83,700 or less	◯ $93,750 or less	◯ $100,200 or less	◯ $106,700 or less
81%+ median	◯ $83,701 or more	◯ $93,751 or more	◯ $100,201 or more	◯ $106,701 or more

Certification (If participant is under the age of 18, this form must be completed and signed by a parent or guardian): *I acknowledge that this information as submitted above has been examined by myself and is true and correct.*

Name: _____ Participant Name (if applicable): _____

Signature: _____ Date: _____

DEFINITION FOR REPORTING TABLE RACE AND ETHNICITY

Racial Categories:

American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, of the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American: A person having origins in any of the black racial groups of Africa.

Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Ethnic Categories:

Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, " Spanish origin," can be used in addition to "Hispanic or Latino."

Not Hispanic of Latino: A person not of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

Data Collection Information for Race and Ethnicity:

All Public Services Subrecipients must use a two-question format, meaning that separate questions for race and ethnicity should be used. Race and ethnicity are not the same thing. Both questions must be answered. The ethnicity question should precede the race question. Self-reporting or self-identification, rather than observer identification is the preferred method for collecting race and ethnicity data. Self-identification for race and ethnicity means that responses are based on self-perception.

West Side Community Services

Sample Day Schedule at WSCS After-School Program*

After School Program Schedule:				Sample
Time	Group #	Location	Activity	Name of Activity
Start Time 2:30pm End Time 3:30pm	All Groups	Cafe	Check in & Meal	
Transition Time at 3:25pm	First Activity			
Start Time 3:30 pm End Time 4:00pm	Pathfinders	Stay & Play room	HomeWork Help	H.H & Activity Sheets
	Navigators	Stay & Play room	HomeWork Help	H&H & Activity Sheets
	Adventurers	Comp Room	HomeWork Help	H&H & Comp 101
Transition Time at 3:55pm	Second Activity			
Start Time 4:05 pm End Time 4:45pm	Pathfinders	Stay & Play room	Collaboration Station	Free Play/Spring Craft
	Navigators	A&C Room	Arts & Culture	Spring Craft
	Adventurers	GYM	"Rec It Up"	CTF
Transition Time at 4:40pm	Third Activity			
Start Time 4:45pm End Time 5:30 pm	Pathfinders	GYM	"Rec It Up"	CTF
	Navigators	Comp Room	Collaboration Station	Improv
	Adventurers	A&C Room	Arts & Culture	Artsy IV
Dismissal Time at 6:00pm	End of Day Dismissal- Stay and Play			

Each child is assigned to a grade/age-level group with developmentally appropriate activities.

Pathfinders: Kindergarten – 1st Grade

Navigators: 2nd-3rd Grade

Adventurers: 4th-6th Grade

*Subject to change. Permanent schedules posted at the front desk/each room.