



Dear Parent/Guardian,

Included in this enrollment packet are the following required forms in order for your child to be enrolled in the Out of School Time Program:

Required Forms

Enrollment Packet

Medication Consent Form - OCFS-7002 (if applicable)

Individualized Health Care Plan - OCFS-7006 (if applicable)

Individual Allergy and Anaphylaxis Emergency Plan - OCFS-6029 (if applicable)

Infectious Disease/COVID-19 Health Policy

Client Characteristic Form

Swimming Waiver

Child & Adult Care Food Program Income Eligibility Form

Bus Information: Your child's bus information needs to be provided to the program before your child starts in the program for either before school, afterschool, or both.

DSS Subsidy: Your approval letter needs to be provided to the program before your child starts in the program if you qualify for the Childcare Assistance Program through Erie County.

Contract - The parent/guardian contract must be filled out completely before starting the program; The contract has the days and times your child(dren) will be attending, and the cost of care for family share and or private pay.

Please feel free to reach out to 716-845-0485 if you have any questions.

Thank you,

Belle Center School-Age Program





YEAR: _____

THE BELLE CENTER: OUT OF SCHOOL PROGRAM ENROLLMENT FORM

PLEASE FILL OUT APPLICATION IN ITS ENTIRETY

YOUTH PROGRAM (5 - 12 years old):		
☐ YOUTH AM PROGRAM Before School - 6:30 AM - 9:00 AM	AM BUS # _____ TIME: _____	Days Needed: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday
☐ YOUTH PM PROGRAM After School - 2:30 PM - 5:30 PM	PM BUS # _____ TIME: _____	Days Needed: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday
☐ SCHOOL RECESS / HOLIDAY'S ONLY	Start Date: _____	

CHILD'S INFORMATION:	
Name (First & Last): _____ Nickname: _____ Gender: ☐ Male ☐ Female	
Date of Birth: ____ / ____ / ____ Age: _____ Grade: _____	
900 # _____ School: _____	
Race: _____ Ethnicity: _____ Primary Language: _____	
Home Address: _____ City: _____ State: _____ Zip Code: _____	
Swimming Ability: (0 = Never Swam; 10 Excellent): 0 1 2 3 4 5 6 7 8 9 10	

APPLICANT/HOUSEHOLD INFORMATION:	
Please Check: ☐ BMHA Housing Resident ☐ Subsidized Housing Resident	
Participant Lives With: ☐ Mom ☐ Dad ☐ Grandparents ☐ Aunt ☐ Uncle ☐ Foster Parent ☐ Legal Guardian	
Parent/Guardian Name (First & Last): _____	
Address: _____ City: _____ State: _____	
Zip Code: _____ Cell Phone: _____ Work Phone: _____	
Email: _____ Occupation: _____	
Is the current head of household... ☐ Male ☐ Female ...a single parent? ☐ Yes ☐ No	



LIABILITY WAIVER/MEDICAL TREATMENT CONSENT:

In consideration for my and/or my family members participation in The Belle Center's program that I wish to register for, I voluntarily RELEASE Erie Regional Housing Development Corporation and the officers, agents, employees, and volunteers, (hereinafter referred to as "releases") from any and all liability for injuries or death or property damage to me and/or my family members resulting from, arising out of, or in any way connected with my and/or any of my family members participation in The Belle Center's recreation programs or use of The Belle Center's facilities in connection with this/these program(s). I understand that this waiver and release is applicable even though the negligent activities of the releases may have contributed to the injury or death or property damage suffered by me or any family members participating in this/these program(s). I further agree to identify and hold harmless the releases from and against any and all liability, claims, causes of action, and/or loss of any kind (including litigation-related expenses such as attorney and expert witness fees) results from participation in this/these program(s) whether caused by any neglect act or omission of the releases.

I further understand that serious accidents may occur in The Belle Center program(s) that I am registering for, that participants in this/these program(s) may sustain mortal or serious personal injuries, and/or property damage, as a consequence of their participation in this/these program(s). Knowing the risk of said events, nevertheless, I hereby agree to assume those risks and to release and hold harmless to the fullest extent allowed by law all of those persons mentioned above who through passive or active negligence or carelessness might otherwise be liable to me for damages.

It is further understood and agreed that this waiver, release, hold harmless, and identification agreement is to be binding on me, any of my participating family members, and all of our heirs, representatives, and assigns.

I hereby authorize qualified physicians to render medical treatment of care that they deem necessary for me or my family members in case of illness or accident during such program(s). In the event of injury of a child participant, and if parent cannot be reached, emergency services and/or the Buffalo Fire Department will be contacted to transport the injured to a nearby local hospital.

Initials: _____

AGREEMENT:

Please read the following and sign.

- **County Child Care Assistance:** I ☐ expect or ☐ do not expect to be eligible for County Child Care Assistance (DSS). **Receipt of approval letter is required before start date.** Payments will only be charged in the event that Erie County DSS determines that there is a "Family Share" cost to be paid to The Belle Center.
- **Enrollment:** I consent to the enrollment of the child listed above at The Belle Center and have been advised of the policies regarding fees (**late pick-up fee \$20.00/child**) and the New York State Department of Social Services regulations under which it operates. I understand that my child care may be suspended if my account is not current within two weeks.
- **Financial Information Release:** Financial information will only be released to those who sign below. Anyone not named below will obtain information from those signed.
- I understand that this is a **Contract for Services**.
- To Complete Registration: Return Registration Form to ERHDC, The Belle Center, 104 Maryland Street, Buffalo, NY 14201.

Signature of Parent/Guardian: _____

Date: _____

THE BELLE CENTER - HOME OF ERIE REGIONAL HOUSING DEVELOPMENT CORPORATION
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EMERGENCY CONTACT FORM				
Child's Full Name:		Gender: ☐ Female ☐ Male		Date of Birth: (MM/DD/YYYY)
Child's Home Address:		Name of Person Applying for Child:		
Does your child have health insurance?: ☐ Yes ☐ No Insurance Carrier: _____ Policy #: _____ Group #: _____		Daytime Telephone #: ☐ Parent ☐ Guardian ☐ Other _____		
Does your child have any allergies? ☐ Yes ☐ No		If yes, what is your child allergic to and what is the reaction?		
Children who have special health care needs are those who have chronic physical, developmental, behavioral, or emotional conditions expected to last 12 months or more and who also require health and related services of a type beyond that required by children generally. Does your child have a chronic physical, mental, developmental, behavioral, or emotional condition? ☐ Yes ☐ No If yes, what is your child's physical, mental, developmental, behavioral, or emotional condition?				
Medications: Medications require a separate form. Complete medication form that is attached.				
Child's Primary Care Physician's Name:		Primary Care Physician's Telephone #:		
Child's Source of Dental Care/Dentist's Name:		Dental Care/Dentist's Telephone #:		
Name of Medical Care Facility/Hospital:		Medical Care Facility/Hospital Telephone #:		
Emergency Data	CONTACT NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBER	AUTHORIZED TO PICK UP?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No





Agreements: I consent to the enrollment of the child listed above in this facility and have been advised of the policies regarding administration of medications, fees, transportation and the services provided by the facility, and the Office of Children and Family Services regulations under which it operates.

I give consent for my child to take part in neighborhood trips (i.e. library, park and playground) away from the facility under proper supervision, including transportation provided by or arranged for The Belle Center's Out of School Program. ☐ Yes ☐ No

In case of accident or injury, I authorize any and all emergency medical, dental, and/or surgical care and hospitalization advised by the physicians, surgeon or hospital (listed above) necessary for the proper health and well-being of my child. ☐ Yes ☐ No

I have provided information on my child's special needs (allergies, diet, disabilities, and/or medical information) to the provider, as may be necessary to assist the facility in properly caring for my child in case of an emergency. ☐ Yes ☐ No

I understand and agree that photographs, videos, or other images may be taken during recreation programs and that I hereby give permission to have my child's photo taken and authorize the use and reproduction of said photos by The Belle Center. All negatives and prints shall become the sole property of The Belle Center. ☐ Yes ☐ No

I give permission for The Belle Center staff to apply sunscreen and insect repellent to my child. ☐ Yes ☐ No

My child is allowed to participate in swimming activities at The Belle Center. ☐ Yes ☐ No

I agree to review & update this information whenever a change occurs and at least once every six months. ☐ Yes ☐ No

Signature of Parent/Guardian: _____

Date: _____

FIELD TRIP ACKNOWLEDGMENT

Please read the following and sign.

Permission slips will be sent home prior to field trips.

Signature

I give permission for my child to participate in field trips.

As such, I acknowledge I am aware of:

- Risks including but not limited to slips, falls, pinches, scrapes, twists, jolts, scratches, bruises, sprains, lacerations, fractures, concussions, or even more severe injuries.
- Potential hazards associated with travel to and from the field trip site.
- Possible contact with plants, animals, or insects that could result in stings, allergic reactions, and associated diseases.

Further, I confirm I have provided:

- Appropriate and available emergency contact information for the duration of all field trips and travel hours.
- All necessary medical information, including a list of allergies, instructions, and medications to the appropriate school staff to ensure adequate care is available while my student is under their supervision.

I **DO NOT** give permission for my child to participate in field trips. I understand that I will be responsible for childcare on days there are field trips.

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RELEASE OF STUDENT ACADEMIC RECORDS AUTHORIZATION

As a parent/guardian of (Child's Name) _____, I, (Parent/Guardian Name) _____, do hereby give permission for release of my child's academic records to The Belle Center's Out of School Program.

Student's Name: _____ Student's Birthday: _____

Name of School: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Name of Child's Most Recent Teacher: _____

Specific information to be released should include the following:

- Most current report card or progress report
- Report cards and standardized testing results from previous year
- Immunization Records
- IEP / 504 Records
- Other: _____

Your timely return of the requested information is appreciated.

- Scan and email to: tboehm@thebellecenter.org
- Fax: 716-845-0486, Attention: Youth Director
- Mail: The Belle Center, Attention: Youth Director, 104 Maryland Street, Buffalo, NY 14201

Signature of Parent/Guardian: _____ **Date:** _____





The Belle Center Infectious Disease / COVID-19 Health Policy

Our priority at The Belle Center is to ensure the health and safety of the children and staff that come to our center every day. We will not be successful without your help! Our new health guidelines are based on recommendations set forth by our local licensing agency, recommendations made by our Health Care Consultant, which were based on The Center for Disease control. The practices are subject to change as needed.

As COVID-19 is still around our community, we are asking each of our families to acknowledge and agree to the following procedures. *This form must be returned before your child can start/return to our program.*

Child's Name: _____		DOB: _____	
I, _____,		_____	
Parent/Guardian		Relationship to Child	
Acknowledge that if my child or any person within my household shows any of the following symptoms, I agree to keep them home for 48 hours or until the child is fever free, without fever reducing medication.			
• Fever over 100.0 • Excessive dry cough • Shortness of breath • Lethargic, overly tired, unusually calm or quiet • Mild respiratory illness/issues			
If my child experiences any of the above symptoms during childcare, I understand that either myself, or a person I have designated as an emergency pick up, will arrive within one hour.			
Administration may request a physician's note to return to care.			
I agree to inform the program if my child, or any family member, has tested positive for COVID-19 so that the program can take necessary mandated steps. Your child's identity will remain confidential.			
Out of respect for the other children, families, and staff members, failure to abide by our policies or failure to disclose COVID-19 exposure or positive test of your child or family member may result in immediate termination from this program.			
<i>I certify and acknowledge that I have read and understand the COVID-19 Health Policy and agree to the terms listed above.</i>			
Signature: _____		Date: _____	
Print Name: _____			
Director Signature: _____		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 (<i>including strength</i>):		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: (<i>signs and symptoms must be observable and, when possible, measurable parameters</i>): _____					
8A. Possible side effects: ☐ See package insert for complete list of possible side effects (<i>parent must supply</i>)					
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 (<i>describe</i>): _____					
10A. Special instructions: ☐ See package insert for complete list of special instructions (<i>parent must supply</i>)					
AND/OR					
10B. Additional special instructions: (<i>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.</i>) _____					
11. Reason for medication (<i>unless confidential by law</i>): _____					
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

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.

[illegible]

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)

X	DATE: / /
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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

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:

THE FOLLOWING STRATEGIES WILL HELP 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: / /



Swimming Pool Waiver and Release of Liability Form

Release of Liability, Waiver of Claims, Assumption of Risk, and Indemnity Agreement

PLEASE READ CAREFULLY. BY SIGNING THIS DOCUMENT, YOU CHOOSE TO WAIVE CERTAIN LEGAL RIGHTS, INCLUDING THE RIGHT TO SUE.

To: Parents and Guardians of the Belle Center

I wish to swim at the Center's pool during Daycare and SACC hours. In swimming at the Center's pool during this time, I recognize and fully understand certain things, including:

- During swim sessions a lifeguard will be on duty at all times.
- The swimmer has to take a swimming test, if not passed then has to wear a flotation device and not go past the deep end line. If passed, the swimmer has the option to take the deep end test, if passed both tests they will receive a bracelet and lifeguard will keep track of who has successfully tested.
- The pool is divided into two sections: a shallow end (depth of shallow end varies from 3ft to 5ft) and deep end (depth of deep end varies from 5ft to 11.5ft)
- My use of the Center's pool during these swim sessions involves certain risks, including:
 - The risk of injury resulting from possible malfunction of the pool equipment;
 - The risk of injuries resulting from tripping or falling over obstacles in the pool area;
 - The risk of injuries resulting from unsupervised divers and swimmers colliding;
 - The risk of other injuries resulting from participating in the swim session.
- I recognize and fully understand that the above list is not a complete or exhaustive list of all possible risks; the list only provides examples of types of risks that I am assuming.

In exchange for the Center allowing me to participate in the swim sessions, I hereby agree to the conditions below. I fully intend and choose to give up the legal rights, as stated below:

1. TO WAIVE ALL CLAIMS that I have or may have in the future against the Owner, its directors, officers, employees, agents, or representatives (hereinafter referred to as the "Releases") Relating to my use of the pool and pool area;
2. TO RELEASE THE RELEASES from any and all liability for any loss, damage, injury, expense, or other cost that I may suffer or that my next of kin may suffer in connection with my use of the Releases pool or pool area to any cause whatsoever, INCLUDING NEGLIGENCE ON THE PART OF THE RELEASES;
3. TO HOLD HARMLESS AND INDEMNIFY THE RELEASES from any and all liability to property, or personal injury to, any third party, resulting from the use of the pool or pool area.
4. That I am over 18 and that I am responsible and will adhere to all the rules of the property.

THE BELLE CENTER - HOME OF ERIE REGIONAL HOUSING DEVELOPMENT CORPORATION

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5. That this Waiver, Release, and Agreement is fully effective and shall be effective and binding upon me, and my heirs, next of kin, executors, administrators, and assigns, or anyone else authorized to act on my behalf or on behalf of my estate

I have read and understood this document. I am aware that by signing this document, I am waiving certain legal rights that I may have against the Releases, and I fully agree that I am over eighteen (or have my adult parent's or guardian's signature below).

Name of Child: _____

Age and Gender of Child: _____

Name and signature of Parent or Guardian:

Date: _____

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Formulario de exención de piscina y liberación de responsabilidad

Liberación de responsabilidad, renuncia a reclamaciones, asunción de riesgos y acuerdo de indemnización

POR FAVOR, LEA ATENTAMENTE. AL FIRMAR ESTE DOCUMENTO, USTED ELIGE RENUNCIAR A CIERTOS DERECHOS LEGALES, INCLUIDO EL DERECHO A DEMANDAR.

Para: Padres y tutores del Belle Center

Deseo nadar en la piscina del Centro durante las horas de guardería y SACC. Al nadar en la piscina del Centro durante este tiempo, reconozco y entiendo completamente ciertas cosas, que incluyen:

- Durante las sesiones de natación una socorrista estará de guardia en todo momento
- El nadador tiene que tomar una prueba de natación, si no se aprueba, entonces tiene que usar un dispositivo de flotación y no ir más allá de la línea de extremo profundo. Si se aprueba, el nadador tiene la opción de tomar la prueba de extremo profundo, si pasa ambas pruebas recibirá un brazalete y el salvavidas hará un seguimiento de quién ha probado o no.
- La piscina está dividida en dos secciones: un extremo poco profundo (la profundidad del extremo poco profundo varía de 3 pies a 5 pies) y un extremo profundo (la profundidad del extremo profundo varía de 5 pies a 11.5 pies)
- Mi uso de la piscina del Centro durante estas sesiones de natación implica ciertos riesgos, que incluyen:
 - El riesgo de lesiones resultantes de un posible mal funcionamiento del equipo de la piscina;
 - El riesgo de lesiones resultantes de tropezar o caer sobre obstáculos en el área de la piscina;
 - El riesgo de lesiones resultantes de buzos y nadadores sin supervisión que colisionan;
 - El riesgo de otras lesiones resultantes de participar en la sesión de natación.
- Reconozco y entiendo plenamente que la lista anterior no es una lista completa o exhaustiva de todos los riesgos posibles; la lista solo proporciona ejemplos de tipos de riesgos que estoy asumiendo.

A cambio de que el Centro me permita participar en las sesiones de natación, acepto las siguientes condiciones. Tengo la intención y elijo renunciar a los derechos legales, como se indica a continuación:

THE BELLE CENTER - HOME OF ERIE REGIONAL HOUSING DEVELOPMENT CORPORATION
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1. RENUNCIAR A TODAS LAS RECLAMACIONES que tenga o pueda tener en el futuro contra el Propietario, sus directores, funcionarios, empleados, agentes o representantes (en adelante, las "Liberaciones") relacionadas con mi uso de la piscina y el área de la piscina;
2. PARA LIBERAR A LOS EXONERADOS de toda responsabilidad por cualquier pérdida, daño, lesión, gasto u otro costo que pueda sufrir o que mis familiares más cercanos puedan sufrir en relación con mi uso de la piscina de Liberaciones o el área de la piscina por cualquier causa, INCLUIDA LA NEGLIGENCIA POR PARTE DE LAS LIBERACIONES;
3. EXIMIR DE RESPONSABILIDAD E INDEMNIZAR A LAS LIBERACIONES de cualquier y toda responsabilidad a la propiedad, o lesiones personales a terceros, resultantes del uso de la piscina o el área de la piscina
4. Que soy mayor de 18 años y que soy responsable y me adheriré a todas las reglas de la propiedad.
5. Que esta renuncia, liberación y acuerdo es plenamente efectiva y será efectiva y vinculante para mí, y mis herederos, parientes más cercanos, albaceas, administradores y cesionarios, o cualquier otra persona autorizada para actuar en mi nombre o en nombre de mi patrimonio.

He leído y entendido este documento. Soy consciente de que al firmar este documento, estoy renunciando a ciertos derechos legales que pueda tener contra las Liberaciones, y estoy totalmente de acuerdo en hacerlo.

Nombre del niño: _____

Edad y sexo del niño: _____

Nombre y firma del padre o tutor:

Fecha: _____

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See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME _____

Print the name of the child(ren) enrolled in this child care center

1. _____ 2. _____ 3. _____

DIRECTIONS

Complete SECTION A if anyone in your household

1. Participates in the Supplemental Nutrition Assistance Program (SNAP)
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR) OR
4. Is a foster child

SECTION A

SNAP Case # _____

TANF # _____

FDPIR # _____

Names of _____
Foster Children _____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true. I understand that the center will get Federal funds based on the information I give.

Signature _____

Date _____

FOR SPONSOR USE ONLY

CACFP Agreement # _____

Total Number of Household Members _____
(INCLUDING FOSTER CHILDREN, IF APPLICABLE)

Total Household Income \$ _____

Free _____ Reduced _____ Paid _____

Date of Determination _____

Signature of _____
Center Staff _____

Complete SECTION B if no one in your household participates in SNAP, receives TANF, participates in FDPIR or if none of the children enrolled in the child care center is a foster child.

SECTION B

List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received **last month** in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, child support, foster child's personal income and any other sources of income.

HOUSEHOLD MEMBER NAME	MONTHLY GROSS SALARY
1. _____	\$ _____
2. _____	\$ _____
3. _____	\$ _____
4. _____	\$ _____
5. _____	\$ _____
6. _____	\$ _____
7. _____	\$ _____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true and that all income is reported. I understand that the center will get Federal funds based on the information I give.

Signature _____

Print Name _____

LAST FOUR (4) DIGITS OF
SOCIAL SECURITY NUMBER

--	--	--	--

DATE _____

USDA is an equal opportunity provider and employer.

Agency: _____
Activity: _____

CLIENT CHARACTERISTIC FORM - CDBG 51

Public Services - Limited Clientele Activities

Staff Reviewed Initial _____

Issue Date: 10/1/25

Revision Date: 5/1/26

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)	☐ \$21,350 or less	☐ \$24,400 or less	☐ \$27,450 or less	☐ \$33,000 or less
50% median (VL)	☐ \$35,550 or less	☐ \$40,600 or less	☐ \$45,700 or less	☐ \$50,750 or less
80% median (LI)	☐ \$56,850 or less	☐ \$65,600 or less	☐ \$73,100 or less	☐ \$81,200 or less
81%+ median	☐ \$56,851 or more	☐ \$65,601 or more	☐ \$73,101 or more	☐ \$81,201 or more
Income Limits	5 Person Household	6 Person Household	7 Person Household	8 Person Household
30% median (XL)	☐ \$38,680 or less	☐ \$43,360 or less	☐ \$50,040 or less	☐ \$55,720 or less
50% median (VL)	☐ \$54,850 or less	☐ \$58,900 or less	☐ \$62,950 or less	☐ \$67,000 or less
80% median (LI)	☐ \$87,700 or less	☐ \$94,200 or less	☐ \$100,700 or less	☐ \$107,200 or less
81%+ median	☐ \$87,701 or more	☐ \$94,201 or more	☐ \$100,701 or more	☐ \$107,201 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: _____