Joe Colon, Recreation Supervisor
973-365-5525/5630
FAX 973-365-5567

CITY OF PASSAIC
MAYOR HECTOR C. LORA
DEPARTMENT OF RECREATION & CULTURAL AFFAIRS
CITY HALL
330 PASSAIC STREET
PASSAIC, NJ 07055-5815

"After-School Special" & "Friday Night Special"

(MUST BE A RESIDENT OF THE CITY OF PASSAIC)

The Department of Recreation and Cultural Affairs offers free quality award winning programs for children and adults who reside in the City of Passaic and/or who have attended Self-Contained classes. We have a low client-to-staff ratio. The two programs outlined briefly below are made possible by the receipt of state grants and city funding. Transportation to and from the program is also provided.

The **"After-School Special"** is designed for children ages 8-16 with special needs. The program meets twice weekly from 4:30pm – 6:00pm and offers swimming, bowling, arts & crafts, and sports instruction. Children are picked up every Wednesday and Friday afternoon throughout the school year. Program dates and times change during the summer months.

The **"Friday Night Special**" is designed for teens and adults with special needs. The program meets every Friday from 5:00pm – 10:00pm. Clients prepare meals, participate in crafts and games, and enjoy movies and mall outings regularly. Trips are regularly scheduled to events such as pro basketball games, circus, movies etc.

Kindly fill out the attached application and return as soon as possible (by mail or in person) to the above address (Attn: Mr. Joe Colon). Your child/adult will be placed on a waiting list and as soon as an opening is available, you will be contacted by our office with a confirmation of acceptance. If you have any questions, please contact Mr. Colon at 973-365-5551 or the Department of Recreation at 973-365-5525/5630.

Sincerely,

Joe Colon
Recreation Supervisor

Department of Recreation & Cultural Affairs
330 Passaic St., Passaic NJ 07055
973-365-5525

After-school Special" & "Friday Night Special"
Application

Name_____ Date of Birth_____

School: _____ Teacher_____

Address_____ Home # _____

Parent/Guardian Name_____ Work # _____
(Please Print Name)

Cell # _____ Other #_____

Emergency Contact Person _____ Relationship_____

Home #_____ Other #_____

Does child/adult use wheelchair?_____ Braces? _____ Or any other means of support for movement? _____

If yes, please describe. _____

Please be advised that child/adult must be able to dress and use the bathroom by him/her self.

We do not administer medication to participants. Please ensure that all necessary medications (if needed) are administered at home before child/adult is picked up.

Describe child/adult's behavior in public situations: _____

Describe the child's speech and communication abilities?_____

What is the most effective way to encourage the child/adult?_____

Your child/adult will be actively involved in running, swimming, bowling, dancing, trips, outings, sports instructions, and craft projects. If there is any activity your child cannot participate in for medical reasons, please describe:

_____

_____

Participant/Parent/Guardian agrees that the applicant is physically able to participate in the sports/activity and further agrees not to hold the municipality and/or any of its agents/members or employees liable in the event of an accident or injury or damage, whatsoever, arising from the participation or presence at an activity.

I hereby give permission to _____ to participate in the Passaic Recreation Special Programs and its activities.

Parent's Signature: _____ Date: _____

Department of Recreation & Cultural Affairs
330 Passaic St., Passaic NJ 07055
(973) 365-5525

HUD INFORMATION

Please read and complete.

Parent/Guardian:
The program for which you are applying is funded by the U.S. Department of Housing and Urban Development. The information requested below is used for funding, statistical purposes and to monitor legal compliance.

We do not discriminate on the basis of race, ancestry, color, religion, national origin, sex (including sexual orientation), medical condition, disability, or age, in any of its policies, procedures or practices.

Child's Last Name: _____ First Name:_____

Address:_____ City_____ State _____ Zip Code _____

Home phone #_____

1. Please select: ☐ Non-Hispanic ☐ Latino/Hispanic

2. Please select:

☐ American Indian/Alaskan Native ☐ Black ☐ Asian ☐ White

☐ American Indian/Black ☐ Black/White ☐ Asian/White ☐ Other Multi-Racial _____

3. Amount of Adults in Household_____ **4**. ☐ Female Head of Household **5.** Amount of Children in Household _____

6. Total Gross Income $ | | | , | | | . | | | **7.** Does the participant have a disability? ☐ Yes ☐ No

I certify that all the information on this form is true and correct. I understand that my statements are subject to verification and any misrepresentation by me will be sufficient cause for rejection of this application. I also understand that this statement may be verified by the City of Passaic or by the Federal Government.

_____ _____

Signature of Parent/Guardian **Date**

Department of Recreation, Cultural & Senior Affairs
330 Passaic St., Passaic NJ 07055
973 365-5525

"After-school Special" & "Friday Night Special"
Health History Form

Name_____ Date of Birth_____

Address_____ Home # _____

Parent/Guardian Name_____ Work #_____
(Please Print Name)

Cell # _____ Other # _____

Emergency Contact Person _____ Relationship _____

Home # _____ Other # _____

Medical Insurance Company _____ Policy #_____

★ Medical Release to Be <u>Completed By the Doctor</u>

Family Doctor _____ Office # _____

Address_____

Dietary
Restrictions_____

Has the child/adult ever experienced or is being treated currently for any of the following:

☐ Physical Handicap	☐ Joint Pain	☐ Fainting	☐ Motion Sickness
☐ Visual Disturbance	☐ Kidney Disease	☐ Diabetes	☐ Wears glasses/contact lens
☐ Skull Fracture	☐ Heart Trouble	☐Rheumatic Fever	☐ Other_____
☐ Concussion	☐ Seizure/Convulsion	☐ Mononucleosis	☐ Other_____
☐ Hearing Loss	☐ Surgery	☐ Hepatitis	☐ Allergy _____
☐ Stomach Pain	☐ Asthma	☐ Nose Bleeds	_____

Is the child/adult currently taking medication? Yes_____ No_____ If yes, Please list all medications, dosage, and reason for medication. (Attach separate sheet if necessary.)

_____

_____

Should this child/adult's activities be restricted for any reason? Yes_____ No _____ If yes, Please explain:

_____

_____

I have examined this child/adult and have determined that he/she is able to participate in the Passaic Recreation Special Program and its activities.

Doctor's Signature_____ Date_____