DREAM
The Village Mentoring Organization

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New Mentee!

Welcome to DREAM – it's a fun and enriching experience, and we're excited to have your family on board. These forms are extensive, but necessary to ensure safety and fun for all our participants.

Mentee Information

First Name of Youth | Last Name of Youth | Nickname/Preferred Name | Gender

Date of Birth | Race/Ethnicity | Household Language

School Youth Attends | Current Grade in School | Receive free/reduced lunch at school? Yes / No

Youth Email | Youth Home Phone | Youth Cell Phone

Primary Street Address (Youth) | Apartment Number

City | State | Zip Code

Parent/Guardian Information

1) First Name of Parent(s)/Guardian(s) | Last Name | Relationship to Child

Primary Phone Number | Secondary Phone Number | Email Address

2) First Name of Parent(s)/Guardian(s) | Last Name | Relationship to Child

Primary Phone Number | Secondary Phone Number | Email Address

Secondary Street Address (if applicable) | Apartment Number

City | State | Zip Code

Does your child participate in another mentoring program or other afterschool groups? □ **Yes** □ **No**

If YES, what program? _____

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Do you have rules for your child's behavior that you would like to be used during DREAM?

_____

_____

_____

Emergency Contact Information (other than parent & guardian):

1) _____
Name Phone Number Relation to Youth

2) _____
Name Phone Number Relation to Youth

3) _____
Name Phone Number Relation to Youth

Release Waiver

In consideration of my child, (please print name) _____'s, participation in The DREAM Program (which meets regularly on a predetermined day of the week and occasionally on other days of the week) I hereby agree on behalf of myself, my heirs, legates, executors, administrators, and personal representatives, to release and hold harmless all chaperones and mentors, Boston University, Northeastern University, Harvard University, Tufts University, Madison Park Development Corporation and is corporate entities (Adams Orchard LP, Madison Trinity LP, Orchard Gardens, Inc., MTV, Inc., Orchard Gardens Resident Association, Trinity Financial, Lower Roxbury Community Corporation, Haynes House II Associates LP, Madison Park III LP, Madison Park IV LP, Beryl Gardens LP, Ruggles Shawmut LP), Maloney Properties, Inc., Winn Management Company LLC, Cornu Management, Inc., Boston Housing Authority, Cambridge Housing Authority, Somerville Housing Authority, Massachusetts Promise Fellowship, and any and all other persons and organizations assisting The DREAM Program, Inc., from liability for any injury to my child, to my child's property and any and all claims in any manner arising from or associated with my child's participation whether the liability, loss or damage is caused in whole or in part by their failure to use reasonable care in their activities associated with The DREAM Program, Inc. I understand that in case of emergency, The DREAM Program's staff and all other chaperones and mentors have my total permission to use their best judgment in matters of treatment and to have my child treated accordingly.

_____
Signature of Parent/Guardian Date

_____
Signature of Child Date

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Media and Surveys Release

I hereby grant to The DREAM Program, Inc. (“DREAM”) permission to periodically administer surveys to me and my child. I also hereby grant to The DREAM Program, Inc. (“DREAM”), or any of its agents, the right and permission, with respect to the surveys, photographs, and video which DREAM or its agents have taken of me or my children, or in which I/we may be included with others, to copyright the same in its own name or otherwise; to use, reuse, publish and re-publish in the same in whole or in part, in conjunction with any printed matter in any and all media now or hereafter known, and for any purpose whatsoever, for illustration, promotion, art, advertising and trade, or any other purpose; and to use my name, my children’s names, and any statement made by me or my children, in connection therewith if DREAM so chooses. I have read the foregoing and fully understand the contents hereof. This release shall be binding upon me and my heirs, legal representatives and assigns.

_____

Signature of Parent/Guardian Date

Optional Information

Federal funding has been made available to mentoring programs who match children of incarcerated parent with mentors. If you feel comfortable, please answer the following questions.

- Does the above child have a parent in prison? □ **Yes** □ **No**
- Does the above child have a parent on furlough? □ **Yes** □ **No**

The DREAM Program operates with a core value of inclusion, and strives to be supportive of all participants regardless of their race, color, sex, sexual orientation, gender identity, religion, disability, age, veteran status, ancestry, or national or ethnic origin.

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School Waivers

There are two waivers below.

1. Allows for staff and volunteers who are involved with DREAM to connect with your child's school to create a consistent and connected support system.
2. Allows for staff and volunteers who are involved with DREAM to pick your child up from his/her school if necessary for participation in a DREAM activity.

Please fill out and sign each waiver for which you would like to provide DREAM additional permissions to interact with your child and their school community.

1. School Connections

In consideration of my child, _____'s, participation in The DREAM Program, I allow DREAM mentors and staff to communicate with school personnel about relevant information regarding my child's work at school and his/her mental and physical health and well being. I hereby agree on behalf of myself, my heirs, legates, executors, administrators, and personal representatives, to release and hold harmless all mentors, The DREAM Program, Inc., the _____ school and school personnel, and any and all other persons and organizations assisting The DREAM Program, Inc., from liability for any communication with school personnel about my child.

_____

Signature of Parent/Guardian Date

_____

Printed name of Parent/Guardian Date

2. School Pick-up

To enable my child, _____'s, participation in The DREAM Program, I allow DREAM mentors and staff to pick up my child from school. I hereby agree on behalf of myself, my heirs, legates, executors, administrators, and personal representatives, to release and hold harmless all mentors, The DREAM Program, Inc., the _____' school and school personnel, and any and all other persons and organizations assisting The DREAM Program, Inc., from liability for transportation of my child.

_____

Signature of Parent/Guardian Date

_____

Printed name of Parent/Guardian Date

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Youth Medical/Personal Care Information

1) Current Weight in Pounds: _____

2) Is your child allowed to swim while participating at DREAM? □ **Yes** □ **No**

3) How would you describe your child's swimming ability? □ **Strong** □ **Medium** □ **Weak** □ **Non-swimmer**

4) Is your child affected by any allergies (common allergies are to insect bites, latex and food)? □ **Yes** □ **No**

If YES, please list the allergies: _____

_____

If YES, please answer the following questions to help DREAM respond to allergic reactions:

- Can your child have a reaction just from being near the allergen (airborne or inhaled), or does s/he have to come in contact with the allergen? _____
- Please describe what happens to your child if exposed to each allergen:

  _____
- Is your child aware or able to feel the allergic reaction coming on? □ **Yes** □ **No**
- Does your child take any prescription or over-the counter medications for a reaction? □ **Yes** □ **No**

  What medications are administered? _____

5) What year was your child's last immunization for Tetanus? _____

6) Does your child currently have any health concerns or medical conditions that could be restrictive to activities at DREAM? Please check from list below or fill in the blank if not listed:

□ Asthma	□ Seizures	□ Braces
□ Diabetes	□ Heart disease	□ Bed wetting
□ Fainting	□ High blood pressure	□ Glasses/contacts lenses
□ Lyme disease	□ Hearing impairment	□ Lungs
□ Ears, Nose, Throat	□ Digestion	□ Other_____

If you checked any of the above, please explain: _____

_____

7) Does your child regularly take any prescription or over-the counter medications that would potentially need to be administered at a DREAM activity or a DREAM overnight trip/camp? □ **Yes** □ **No**

If YES, please answer the following questions to help DREAM administer medications:

- What is the name of the medication your child takes? _____
- What is the dosage and frequency (time of day, how often) for administration?

  _____
- How is the medication stored? _____
- Can your child take the medication on their own, without supervision? □ **Yes** □ **No**
- Is your child able to swallow a pill to take over-the-counter medication? □ **Yes** □ **No**

*****REMINDER: A copy of the prescription OR the original prescription bottle MUST be included.*****

Youth Medical/Personal Care Information (continued)

During DREAM activities, it may be important for staff or mentors to administer basic first aid or basic care that may include **over-the-counter** medications. Please indicate which medications from our standard first aid kits that may be administered to your child. Unless directed otherwise, medication would be administered as directed by package labeling.

	Yes	No
• Tylenol/Acetaminophen for pain, headache, fever	□	□
• Advil / Ibuprofen for pain, headache, fever	□	□
• Hydrocortisone cream	□	□
• Benadryl/Diphenhydramine for severe itchiness	□	□
• Neosporin or other antibiotic ointment or cream	□	□

Lice Check

It is DREAM policy that every child will be checked for lice before going on overnight trips. This check will be discrete and confidential. If lice are found, the parents will be notified. Appropriate treatment with an over-the-counter lice shampoo will be provided and the child's clothes and belongings will be washed. If you have any questions or concerns, please contact the DREAM office.

Physician and Insurance Information

Name of Child's Physician _____ Physician Phone Number _____

Insurance Company _____ Policy/Group Number _____

Name of Primary Member _____ Medicaid Number _____

Consent to Treat

This health history is correct and complete as far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me. I (parent or legal guardian) hereby give permission to the DREAM staff and/or volunteers to provide routine health care, administer medications, to seek emergency medical treatment if necessary, and to provide or arrange necessary related transportation for my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the DREAM staff and/or volunteers to secure and administer treatment, including hospitalization, for my child.

Signature of Parent/Guardian _____ Date _____

Printed name of Parent/Guardian _____ Date _____