



## **AFTER SCHOOL SERVICES at The Elaine Clark Center and Heart of Hope Academy**

For more than four decades, the Elaine Clark Center has supported children with special needs and their families by providing an innovative model of education and therapeutic play. During the summer of 2009, the Elaine Clark Center completed a merge with Heart of Hope Academy, a small non-profit school that serves children with developmental challenges between the ages of 6 to 22.

The Elaine Clark Center and Heart of Hope Academy is an innovative model of education, therapeutic play and experiential opportunities in a loving and safe environment for all children, regardless of age or ability that enables each child to reach his or her full potential for growth and development to become proud, independent, contributing citizens of the community.

### **AFTER SCHOOL OPPORTUNITIES**

To facilitate a successful after school experience for each participant, we maintain a low staff-to-participant ratio during after school. This allows staff to fully and successfully integrate our participants into the activities in which their peers are involved. Activities are developed and implemented to engage participants where his or her interests are as well as improving his or her socialization skills with peers and motor skills in a safe, nurturing environment and sports setting.

As a newly expanded organization, we are striving to provide more after school options for children with special needs and their families, particularly meeting the children where their abilities and interests are

#### **After School at the Elaine Clark Center (AGES 5-22)**

All activities are on campus at the Elaine Clark Center in a comfortable and safe environment in which participants, whatever their abilities, can participate and select from a variety of fun, therapeutic activities with their peers. Activities range from outdoor play to inside sensory gym to social games and art projects.

#### **After School Enrichment Program (AGES 6-22)**

With a low staff-to-participant ratio, daily activities such as swimming, sports and fitness are essential in the development of a child with special needs. All activities are off campus and are adapted to each student's level of functioning to help ensure he or she receives the most therapeutic benefits and has fun in a social setting. (Note: Participants must be able to maintain successfully within a ratio setting of 3:1 and is independently toileting)

**Please note: After school participants may require an assessment to determine his or her successful placement**

**For more information, contact Shon at 770-458-3251 or [shon@heartofhopeacademy.org](mailto:shon@heartofhopeacademy.org)**

## **Spring 2010 Enrichment Schedule:**

**Monday - Adaptive Instructional Tennis:** We are excited about our partnership with Special Pops Tennis, a volunteer-based adaptive tennis lessons program for individuals with specials. Tennis is an excellent lower-impact exercise that improves circulation, and gross and fine motor skills and helps build self-confidence and life skills through social interaction with other participants and the program volunteers.

**Tuesday, Thursdays & Fridays – Adaptive Swimming Lessons:** Through the Adaptive Swimming Lessons program at the Cowart-Family YMCA on Ashford Dunwoody Rd., participants will receive adaptive swimming lessons, along with some free swimming time. Students will build endurance, flexibility and strength, along with having fun and enjoying social interaction in an inclusive setting. Swimming is a wonderful sensory stimulating activity that promotes relaxation and lessens anxiety.

**Wednesday – Sports & Fitness Circuit:** This year we are lucky to participate in sports such as tennis, track and obstacle course, racquetball and basketball. Students will work on proper hand placement and beginning swinging techniques. We will also be doing fun aerobic exercises and strength-training with light hand weights and low-impact equipment. Our activities strengthen muscles, improve circulation and improve gross & fine motor skills, all within a social setting.

*Structured group activities will be scheduled during times students are at the center.*

### **PICK UP**

Participants can be picked up between 5:00-6:00pm at The Elaine Clark Center. A late charge of \$1.00 per minute will be billed to you for pick up after 6:00pm. Parents MUST sign their children out upon pick up.

NOTE: Only special pre-arranged circumstances will allow for pick up at the off-site enrichment facility where the classes are taking place. Outdoor play, arts, crafts, and group activities will be scheduled for the time students are not offsite at an activity.

It is necessary to bring appropriate clothing for the program your child has chosen. The following list should be helpful:

**Monday:** Adaptive Tennis Lessons – shorts/sweats, closed-toe shoes (Tennis Shoes), water bottle

**Tuesday, Thursday & Friday:**

Adaptive Swimming Lessons - Towel, swimwear, water bottle (extra change of clothes); Clear lens goggles; and two highly preferred diving toys/rings

**Wednesday:** Sports & Fitness Circuit - tennis shoes/sneakers, clothing for exercise, water bottle



**AFTER SCHOOL SERVICES  
SPRING 2010 APPLICATION**  
(Please use a separate form for each participant\*)

Participant's First Name: \_\_\_\_\_ MI \_\_\_\_\_ Last Name: \_\_\_\_\_

Nick Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Birthdate: \_\_\_\_\_

County of Residence: \_\_\_\_\_

**AFTER SCHOOL SERVICES OPTIONS:**

**After School Program Weekly (\$95/week)** \_\_\_\_\_  
**Add Enrichment Option (\$15/day)** \_\_\_\_\_  
 (Mon \_\_\_ Tues \_\_\_ Weds \_\_\_ Thurs \_\_\_ Fri \_\_\_)

**After School Per Day– Enrichment Only (\$30/day)**  
**\*Transportation (limited areas-\$10/week)** \_\_\_\_\_  
 Monday \_\_\_\_\_ Tuesday \_\_\_\_\_ Wednesday \_\_\_\_\_  
 Thursday \_\_\_\_\_ Friday \_\_\_\_\_

**Important Note: If your child is new to The Elaine Clark Center or Heart of Hope Academy, we will contact you to schedule an assessment for your child upon receipt of your application for enrollment. An assessment is required prior to your child's participation in the program. A first time enrollment fee of \$50.00 is due with application.**

**Primary Family Contact (Parent or Guardian)**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Relationship to Camper: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

E-mail: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**\*Transportation is be available for very limited areas and is for pickup for Enrichment activities only. Picking up participants from after school will be at The Elaine Clark Center. Please ask about transportation in your area.**

**CENTER HOURS: 7:30 a.m. to 6:00 p.m.**  
 (Parents picking their children up after 6:00 p.m. will be charged a late fee of \$1.00 per minute.)

**IF THIS CHILD IS CURRENTLY IN FOSTER CARE PLEASE COMPLETE THIS PORTION**

FOSTER PARENT(S) NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ COUNTY \_\_\_\_\_ ZIP \_\_\_\_\_

WORK NUMBER \_\_\_\_\_ HOME NUMBER \_\_\_\_\_

CASEWORKER'S NAME \_\_\_\_\_

COUNTY \_\_\_\_\_ AGENCY \_\_\_\_\_

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**EMERGENCY CONTACTS  
(Other than Parents)**

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

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ COUNTY \_\_\_\_\_ ZIP \_\_\_\_\_

WORK NUMBER \_\_\_\_\_ HOME NUMBER \_\_\_\_\_

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

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ COUNTY \_\_\_\_\_ ZIP \_\_\_\_\_

WORK NUMBER \_\_\_\_\_ HOME NUMBER \_\_\_\_\_

**PARENT INFORMATION**

MOTHER (FULL NAME) \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

CELL PHONE \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ MARITAL STATUS M \_\_\_ S \_\_\_ D \_\_\_ W \_\_\_

FATHER (FULL NAME) \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

CELLPHONE \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ MARITAL STATUS M \_\_\_ S \_\_\_ D \_\_\_ W \_\_\_

**BROTHERS AND SISTERS**

NAME	D.O.B.	LIVING IN THE HOME

**OTHERS LIVING IN THE HOME**

NAME	D.O.B.	RELATIONSHIP

## MEDICAL AND EDUCATIONAL PROVIDER INFORMATION

PEDIATRICIAN \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

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DEVELOPMENTAL EVALUATION \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

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HOSPITAL \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

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OTHER \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

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OTHER \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

***ALLERGY INFORMATION***

CHILD'S NAME \_\_\_\_\_ D.O.B. \_\_\_\_\_

PLEASE LIST ALL ALLERGIES KNOWN TO YOU THAT YOUR CHILD HAS. IT IS MANDATORY THAT WE HAVE THIS INFORMATION IN OUR FILES.

**FOODS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DRUGS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OTHER :** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**COMMENTS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NOTE: PLEASE PROVIDE A DOCTORS LETTER STATING THAT YOUR CHILD IS NOT TO HAVE THESE FOODS WHILE AT SCHOOL.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE

## THE ELAINE CLARK CENTER PARENT AGREEMENT

CHILD'S NAME \_\_\_\_\_ DOB \_\_\_\_\_

1. I/We understand that the Elaine Clark Center will provide a program of education and therapeutic play in a loving and safe environment for my child. The Center will provide a nutritional breakfast and lunch for the child, and, if he/she is in attendance at 2:30, the center will also provide an afternoon snack.
2. I/We understand that my child will be going out of doors every day the weather permits and I/We agree to send appropriate outer clothing (coat, hat, boots) to the center every day.
3. I/We agree to release the Center from any responsibility for property damage, illness, accidents, or injury incurred by the child at the Center not due to negligence on the part of the staff personnel.
4. My/Our child's primary care physician is \_\_\_\_\_,  
and his/her telephone number is \_\_\_\_\_.
5. I/We understand that I/We must complete a Permission Form For Medications (Attachment C in the Parent Handbook) before the nurse at the Center will dispense any medication, breathing treatment, tube feeding, or any other medical procedure.
7. I/We agree to show evidence of age appropriate immunizations as needed.
8. I/We agree to allow this child to be transported in case of an emergency by ambulance, understanding that this Center will not be responsible for accidents or injury not due to negligence.
9. I/We agree to allow this Center, at the expense of the undersigned, to institute emergency medical treatment through my family physician or other recognized medical resource. When possible, the Center shall contact the undersigned prior to such action.
10. I/We agree to permit the staff of this Center to obtain emergency medical transportation for this child at the expense of the undersigned.
11. I/We understand that I am responsible for keeping the Center advised of any significant changes as the changes occur in the information that I provided at the time of enrollment concerning work locations, emergency contacts, family physician, etc.

12. I/We understand that the Center will not permit my child to enter or exit the Center without an escort.

13. I/We agree to allow this Center to administer any educational assessments needed with the understanding that such information obtained shall be kept strictly confidential and be used in developing an individual education program for this child.

14. I/We agree to permit the use of volunteers and university trainees to work with this child as part of this child's program at the Center. I understand for the volunteers or university students, to provide service to this child, it may be necessary for these volunteers and trainees to have access to this child's records. I further understand that these volunteers and students are instructed in confidentiality.

15. I/We agree to permit this child to be photographed or filmed in conjunction with educational and social activities, as well as for the Center's assistive technology training video which will be marketed nationwide. These photographs and films may be used to publicize and promote the Center.

17. I/We agree with this center's policy of multi-age grouping of the two and three years old students. The ratio in the classroom will remain at the two year old state required ratio, however the educational instruction will be individualized and meet the needs of each child participating in the program.

18. I/We understand that if I/we would like to have our infants/child mouth swabbed after meals or our brush his or her own teeth, I/we will provide the center with written permission and a single use only disposable toothette to be used with your child.

I/We have read and are not in agreement with item(s) \_\_\_\_\_

Please Explain \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent

This Report is  
CONFIDENTIAL

Please Return to:  
The Elaine Clark Center  
5130 Peachtree Industrial Blvd.  
Chamblee, GA 30341



Pertinent Medical History

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Surgical History	Date	Type	Results
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Diagnosis

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Prognosis

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Current Medication

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Allergies

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Is child under the care of another physician or health agency? \_\_\_\_\_

Are Physical/Occupational/Speech/Feeding evaluation and follow-up recommended? How often?

\_\_\_\_\_ yes \_\_\_\_\_ no

Special Instructions regarding: Physical and Occupational Therapy and Feeding:

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Limitations on Physical Activity

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Contraindications or Precautions

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Significant medical implications for this child's education

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Additional Recommendations and Comments

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Date of Last Visit \_\_\_\_\_

Date of Next Visit \_\_\_\_\_

***I hereby certify that the above named child is under my care and recommend that he/she :***

\_\_\_\_\_ ***is*** medically stable to participate in the Interactive Sensorimotor Program at the Elaine Clark Center.

\_\_\_\_\_ ***is not*** medically stable to participate in the Interactive Sensorimotor Program at the Elaine Clark Center.

Examiner's Name (please print)

Examiner's Signature

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Name of Health Clinic or Agency

Street Address

City, State, Zip

Phone Number

Name: \_\_\_\_\_ Date \_\_\_\_\_

