

Atlantic Street Center – Summer Academy 2025 Application

Information for Parent/Guardian:

We are now accepting applications for students that are going into 3rd – 8th grade for the 2025/2026 school year. This means students must have completed at least 2nd grade. Only 40 students will be enrolled. Priority will be given to timely applications and Seattle Public School students.

Thank you for taking the time to fill out and turn in this application. **Please understand that submitting this application does not guarantee acceptance into Summer Academy 2025.** You will be notified by mail of the applicant's status when the committee has finished reviewing all the applications. Applications can be turned in at one of the locations below **or emailed to Tiffany Victory at tiffanyv@atlanticstreet.org**:

Atlantic Street Center Cloverdale

5150 S. Cloverdale Pl
Seattle, WA 98118
(206) 723-1301

Hours this site is accepting applications:

Mon & Fri	9am-5pm
Tues- Thurs	10am-6pm

Atlantic Street Center

2103 South Atlantic Street
Seattle, WA 98144
(206) 329-2050

Hours this site is accepting applications:

Mon-Fri	9 am to 5 pm
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Important Dates: Summer Academy dates: July 7th - August 8th, 2025

6/9/2025 Complete Applications are due to Atlantic Street Center. Late or Incomplete applications **will not** receive priority.

6/9 - 6/20/2025 Applications are reviewed by the Summer Academy Committee and applicants are selected for admission.

6/20/2025 Parent/Guardians are notified by email or phone call of applicant's status. Applicants will either be "admitted" or "waitlisted".

Summer Academy Location:

Atlantic Street Center - Cloverdale
5150 South Cloverdale PL
Seattle, WA. 98118

If you have any questions or concerns, please contact:

Tiffany Victory, Youth Development Program Coordinator Atlantic Street Center
Youth Development Program 5150 S. Cloverdale Pl, Seattle, WA 98118

(206) 226-0446

Tiffanyv@atlanticstreet.org

Directions

- **Incomplete applications cannot be considered for admission.** Please review the application carefully before it's submitted. Please do not submit the application to Atlantic Street Center in sections. The application must be submitted in its entirety.
 - **Page 3** – This section should be filled out very carefully. Please provide both the information about the applicant and about the parent/guardian.
 - **Page 4** – This section is required for an applicant to participate in Summer Academy 2025. Please initial the transportation section, the medical release, and the photography permission. If you do not initial all three, the applicant cannot be considered for admission. Please clearly print your full name, then sign and date the general permission at the bottom of Page 4. If this is not signed and dated, the applicant cannot be considered for admission.
 - **Pages 5-7** – These pages are required if the applicant needs medication while at Summer Academy 2025. If the applicant needs to take any medication while at Summer Academy 2025, please carefully fill out this section. If there is no signature, the applicant cannot receive any medication at Summer Academy 2025.
 - **Page 8** – Transportation for Summer Academy 2025 is extremely limited and **is not guaranteed**. Transportation will be considered upon request.
 - **Page 9** - This is the Participant Grievance Form and must be signed in order to be considered for Summer Academy 2025 admission.
 - **Page 10** - This is the additional medical form and must be completed in addition to the sections filled out on pages 5-7 even if information is repeated.
 - **Page 11** - This form shows the acknowledgment by the participant's guardian(s) that they have read, completed, received, and understood all parts of this application.
 - Please have the applicant's **teacher fill out both pages, and sign.** **The application cannot be submitted without the teacher section completed.**
 - Students must be able to attend all weeks of Summer Academy. Please let our staff know in advance of any planned vacations/time away.

*****Parent Orientation is mandatory to attend*****

Please choose the time you will attend Parent Orientation by marking an X your chosen time slot below.

Wednesday June 25 (in person)

11:00 am - 12:00 pm

5:30 pm- 6:30 pm

Thursday June 26 (Zoom sessions)

11:00 pm - 12:00 pm

5:00 pm - 6:00 pm

Address for meeting: Atlantic Street Center
 Cloverdale Location
 5150 S. Cloverdale
 Seattle, WA. 98118
 (206) 723-1301
 (206) 226-0446

Atlantic Street Center – Summer Academy 2025 Application

(Please Print Clearly)

Summer Academy 2025 Applicant Section

Applicant First Name				Applicant Last Name			
Applicant Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	_____/_____/_____ Applicant Birth Date (mm/dd/yyyy)			Applicant Phone Number(s)			
Address	_____ Street Apt. # City Zip Code						
Do you receive Free or Reduced School Lunch? <input type="checkbox"/> Yes <input type="checkbox"/> No Student ID: _____							
School Name			2024/2025 School Year Grade Level		Teacher Name		
Ethnicity/Race (Select all that apply): <input type="checkbox"/> White or Caucasian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Black, African American <input type="checkbox"/> Other Caucasian: _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Chinese <input type="checkbox"/> Ethiopian <input type="checkbox"/> Arab <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Japanese <input type="checkbox"/> Oromo <input type="checkbox"/> Persian/Middle Eastern <input type="checkbox"/> Samoan <input type="checkbox"/> Vietnamese <input type="checkbox"/> Eritrean <input type="checkbox"/> Other : _____ <input type="checkbox"/> Other Pacific Islanders, _____ <input type="checkbox"/> Cambodian <input type="checkbox"/> Somali <input type="checkbox"/> Filipino <input type="checkbox"/> Korean <input type="checkbox"/> Other African: _____ <input type="checkbox"/> Laotian <input type="checkbox"/> Thai <input type="checkbox"/> Other Asian, _____							
Spanish/Hispanic/Latino (Select all that apply): <input type="checkbox"/> Mexican/Mexican-American/Chicano <input type="checkbox"/> Cuban <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Other Spanish/Hispanic/Latino: _____ <input type="checkbox"/> Not Spanish/Hispanic/Latino							
Please check the appropriate box: Homeless: <input type="checkbox"/> Yes <input type="checkbox"/> No New Arrival to U.S. : <input type="checkbox"/> Yes <input type="checkbox"/> No Applicant has limited English: <input type="checkbox"/> Yes <input type="checkbox"/> No Disability: <input type="checkbox"/> Yes <input type="checkbox"/> No							

Parent/Guardian Section

Parent/Guardian First Name				Parent/Guardian Last Name			
Parent/Guardian Home Phone				Parent/Guardian Work/Cell Phone			
Parent/Guardian Email: (Please Print Clearly)				Language Spoken at Home:			
Household Information: Total Number of People in Household: _____ Total Number of Children in Household: _____ Yearly Household Income: _____ Select One: <input type="checkbox"/> Single parent female household with minors under 18 <input type="checkbox"/> Single male adult household <input type="checkbox"/> Single parent male household with minors under 18 <input type="checkbox"/> Partnered/married household with no minors <input type="checkbox"/> Two parent household with minors under 18 <input type="checkbox"/> Other related adults household with no minors <input type="checkbox"/> Other related household with minors under 18 <input type="checkbox"/> Unknown household composition <input type="checkbox"/> Single female adult household							

To be completed by Parent/Caregiver

If a parent/guardian cannot be reached in the case of an emergency, who would you like us to contact?

Emergency Contact First Name		Emergency Contact Last Name	
Emergency Contact Home Phone		Emergency Contact Work/Cell Phone	
Emergency Contact Relationship to Applicant			

Atlantic Street Center Participation Information

Has anyone in your family participated in an Atlantic Street Center program during this school year (2024-2025)?

☐ No ☐ Yes, Name/s:

If yes, at which Atlantic Street Center site/s?

☐ Atlantic Street Center ☐ Cloverdale Site ☐ School _____ ☐ Other:

Has your child participated in Atlantic Street Center's Summer Academy in the past? ☐ No ☐ Yes Year/s: _____

A parent or guardian must initial all of the following releases and the sign the general release
In order for the above-named youth to participate in Summer Academy.

Transportation Authorization

My child has permission to participate in field trips and transportation to/from activities including but not limited to local visits to the library, parks, or other trips scheduled, by means of walking, bus or van.

Parent/Guardian Initials: _____

Medical Release

In authorizing my child's participation, I fully understand the possibility of injury to my child and authorize Atlantic Street Center to give consent for medical treatment when I cannot be contacted within a reasonable time and when such treatment is deemed necessary by the physician.

Parent/Guardian Initials: _____

Photography Permission

I give permission for Atlantic Street Center to use, without limitation or obligation, photographs, film footage or tape recordings which may include my child's image or voice for purposes of promoting or interpreting Atlantic Street Center's programs.

Parent/Guardian Initials: _____

General Permission

I, the undersigned parent or legal guardian of the above-named child, give my consent for my child to participate in Atlantic Street Center's programs. The information on this form will not be provided to any person, agency or group outside of Atlantic Street Center.

I assume responsibility and liability for the behavior and actions of this child when s/he is involved in Atlantic Street Center programs and release the program staff of Atlantic Street Center and any volunteer associated with the program from responsibility or liability for any injuries, damage or personal loss incurred while participating in Atlantic Street Center programs.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date(mm/dd/yyyy): _____

To be completed by Parent/Caregiver

Health Registration Form (Part 1)

Applicant First Name _____		Applicant Last Name _____		Date of Birth (mm/dd/yyyy) _____		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Parent/Guardian First Name _____		Parent/Guardian Last Name _____					
Home Phone			Cell/Work Phone				
Doctor or Clinic			Doctor or Clinic Phone				

Does the applicant have

- Allergies? NO / YES (If yes, please list)
- Asthma? NO / YES (If yes, list triggers) *Indicate: Mild Moderate Severe*
- Learning disabilities? NO / YES (If yes, please list and/or explain)
- Diabetes? NO / YES (If yes, please explain)
- Are there any other concerns?

- Does the applicant take medication of any kind? _____ (If yes, please explain)

To be completed by Parent/Caregiver

Health Registration Form (Part 2)

If applicant needs medication while at Summer Academy, please fill out the information below:

Applicant First Name _____	Applicant Last Name _____	Date of Birth (mm/dd/yyyy) _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
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Please check only one box:

- ☐ I request that authorized persons at Summer Academy assist my child in taking the medicine(s) described below.
- ☐ I request that my child be allowed to self-administer medication.

I shall hold harmless and indemnify Atlantic Street Center's officers, employees and agents against all claims, judgments, or liabilities arising out of the administration and/or self-administration of medication.

Date (mm/dd/yyyy) _____	Print Parent/Guardian Full Name _____	Signature _____
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Diagnosis for which medication is given:

Name of medicine: _____	Dose: _____
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☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

If medicine is to be given **daily**, at what time?

If medicine is to be given **as needed**, describe indications:

How soon can it be repeated?

Is child authorized to medicate himself/herself? ☐ Yes ☐ No

Emergency procedure in case of serious side effects:

To be completed by Doctor or ARNP if medication is required

I have reviewed this Health Registration Form and concur that administration of the medication is necessary/likely to be administered during Summer Academy 2025.

Date (mm/dd/yyyy) _____	Print Name _____	Doctor/ARNP Signature _____
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To be completed by Parent/Caregiver

Transportation Request (PLEASE MARK)

Transportation for Summer Academy 2025 is extremely limited, and ***is not guaranteed***. We will do our best to accommodate students with the highest needs, but there is no guarantee of transportation. Please indicate whether or not you will need transportation.

YES

NO

<div> <div>Applicant First Name</div> <div>Applicant Last Name</div> <div>Date of Birth (mm/dd/yyyy)</div> </div>			
<div> <div>Parent/Guardian First Name</div> <div>Parent/Guardian Last Name</div> </div>			
Home Phone		Cell/Work Phone	
Email Address			

Explanation of Need

Please use this section to explain why transportation is required. Any information that you would like Atlantic Street Center to consider when reviewing this request for transportation should be included. Please be as detailed as possible. Feel free to attach a separate page if need be.

POLICY

It is the policy of Atlantic Street Center to provide a formal grievance process for all participants in accordance with applicable state law. The participants' right to file a grievance, due process, and freedom from retaliation is guaranteed.

PROCEDURES

The participant has the right to designate or appoint a representative. This can be a family member, friend or advocate. Filing of a grievance shall be held confidential and will not be reflected in the participant's record in accordance with applicable regulations.

Services will continue during the grievance process in accordance with best practices.

In the event that the existing participant relationship cannot be maintained or by participant request, an alternative service provider will be assigned to provide services pending resolution of the grievance.

A staff person who is the object of a grievance shall not participate in the grievance process.

If the participant decides to file a grievance:

- Participant obtains a Participant Grievance Form from the receptionist.
- If the participant requires help in completing the form, he/she may ask any staff member (not involved in the grievance) to help complete the form.
- After completion of the form, the form is signed by participant, representative and the receptionist prior to copying. This will document the receipt of the grievance.
- A copy is made of the completed grievance form.
- The original is placed in an envelope and routed to the Program Manager or to the Associate Director, if the Program Manager is involved in the grievance.
- The copy is retained by the participant.
- The entire investigation of the grievance shall be documented.
- A written report of the investigation and disposition of the grievance shall be given to the participant within 30 days of its completion.
- The participant signs off on the disposition, if an agreement was reached.
- The resolved grievance paperwork is filed in the Grievance File maintained in the Human Resources Department
- No mention of any part of the grievance or grievance procedure shall be indicated in the participant's record.

Grievance Appeals:

1st Appeal:

The participant can appeal the grievance decision within ten working days. If the participant appeals the grievance decision:

- The entire documentation of the grievance is routed to the Executive Director.
- The Executive Director shall provide the participant with a written report of the decision/disposition to the participant within 30 days of filing the appeal.
- The participant signs off on the disposition, if an agreement was reached.

2nd Appeal:

The participant can appeal this decision as well within ten working days. If the participant appeals the Executive Director's disposition:

- The grievance paperwork is routed to the Board of Directors, Executive Committee.
- The Board of Directors Executive Committee shall provide the participant with a written report of the decision/disposition to the participant within 30 days. This decision is final.
- Participant signs off on the disposition, if an agreement was reached.

I received and/or was offered a copy of ASC Grievances Procedures:

Participant Signature

ASC Staff Signature

Date



We understand you have entered much of this information already. However, we utilize the Medical Information Form on a daily basis and require this page filled out completely.

ASC Summer Academy Medical Information Form 2025

CURRENT DATE:

STUDENT NAME:

EMERGENCY CONTACT NAME:

PHONE NUMBER:

PHYSICIAN NAME:

PHONE NUMBER:

Has your child been under care for any allergies or recurring illness? ☐ Yes ☐ No

If YES, please indicate:

Does your child have any known physical, mental or social difficulties for which special consideration should be given at school? ☐ Yes ☐ No

If YES, please indicate:

Are there activities that need to be restricted? ☐ Yes ☐ No

If YES, please indicate:

Is your child on medication? ☐ Yes ☐ No

If YES, list prescription name(s):

Do you give permission for medication to be administered while your child is in the program? ☐ Yes ☐ No

If YES, a doctor's note must be submitted.

Please indicate amount of medication to be give and how often (please list specific instructions).

STUDENT NAME:

***Atlantic Street Center Grievance Policy**

- ☐ I have received and/or was offered a copy of Atlantic Street Center's grievance procedures.

***Transportation Authorization**

- ☐ My child has permission to participate in field trips and transportation to/from activities including but not limited to local visits to the library, parks, or other trips scheduled, by means of walking, bus or van.

***Medical Release**

- ☐ I fully understand the possibility of injury to my child and authorize ASC to give consent for medical treatment when I cannot be contacted within a reasonable time and when such treatment is deemed necessary by the physician.

***Photography Permission**

- ☐ I give permission for ASC to use, without limitation or obligation, photographs, film footage or tape recordings which may include my child's image or voice for purposes of promoting or interpreting Atlantic Street Center's programs.

***General Permission**

- ☐ I, the undersigned parent or legal guardian of the above-named child, give my consent for my child to participate in Atlantic Street Center's programs. The information on this form will not be provided to any person, agency or group outside of ASC.

***General Responsibility**

- ☐ I assume responsibility and liability for the behavior and actions of this child when s/he is involved in Atlantic Street Center's programs.

***General Liability**

- ☐ I release the program staff of Atlantic Street Center and any volunteer associated with the program from responsibility or liability for any injuries, damage or personal loss incurred while participating in ASC's programs.

Parent/Guardian Signature

Date

To be completed by Teacher

Please complete and email to Tiffany Victory,
Program Coordinator at tiffanyv@atlanticstreet.org



Teacher Section Please fill in student's name below.

Summer Academy 2025

Applicant/Student First Name				Applicant/Student Last Name			
Referring Teacher			School			2024-2025 School Year Grade Level	
Student's Primary Learning Style	<input type="checkbox"/> Auditory <input type="checkbox"/> Visual <input type="checkbox"/> Kinesthetic <input type="checkbox"/> Global <input type="checkbox"/> Other:					Fall DRA Score	

Please mark an "X" in each row as it relates to the best description of the student's learning/classroom habits.

Student SPS Number:

	N/A	Excellent	Good	Fair	Poor	Very Poor	Comments
Finishes Assignments							
Class Attendance							
Study Skills							
Conflict Resolution							
Positive Interactions							
Communications Skills							
Overall Writing Skills							
Ideas/Organization							
Writing Fluency							
Penmanship							
Spelling							
Overall Reading Skills							
Sight Words							
Decoding							
Comprehension							
Vocabulary							
Fluency							
Overall Math Skills							
Counting							
Place Value							
Addition							
Subtraction							
Multiplication							
Division							
Story Problems							
Estimations							
Fractions							
Percentages							
Decimals							

To be completed by Teacher

Please fill in student's name below.

☐ Male ☐ Female

Applicant First Name Applicant Last Name Date of Birth (mm/dd/yyyy)

Please identify learning goals for this student in each subject area.

Please share your suggestions for successful ways to work with this student.

Please identify if this student has an IEP, special accommodations, academic process, etc.

Please provide other information you feel is pertinent to making this 5-week program a success for this student.

Teacher Name

Teacher Signature

Date (mm/dd/yyyy)

Teacher Email Address: