TASC

82nd Street Academics After School Program @ TRCS

STUDENT ENROLLMENT and HEALTH FORM

This form must be completed and signed by the parent or guardian of a student enrolling in the after-school program.
Only completed forms will be processed.

STUDENT INFORMATION

Student Name _____ Home Phone (_____)_____

Home Address_____ Zip Code _____
Apt. #

City: o Bronx o Brooklyn o Manhattan o Queens o Staten Island

Birth Date _____/_____/_____ Sex o M o F Primary Language Spoken _____
Mo. Day Year

Race/Ethnicity *(select all that apply)* o American Indian o Asian (Non-Hispanic) o Black (Non-Hispanic) o Hispanic/Latino
(optional) o Pacific Islander o White (Non-Hispanic) o Other

_____ _____ _____ Student I.D. #__ __ __ __ __ __ __ __ __
Grade School Homeroom Teacher 9 digit NYC Dept. of Ed. #

Does your child receive free or reduced price lunch? o Yes o No

Will you be enrolling other children into the program? o Yes o No If *yes*, please complete the following:

_____ _____ _____ _____
Student Name Grade School Homeroom Teacher

_____ _____ _____ _____
Student Name Grade School Homeroom Teacher

PARENT/GUARDIAN INFORMATION

Parent/Guardian #1

Name_____ Relationship to student _____

Live in same home? o *Yes* o *No* If *no*, please complete the following: Home Phone (_____)_____

Home Address_____ Zip Code _____
Apt. #

City: o Bronx o Brooklyn o Manhattan o Queens o Staten Island Email _____

Work Phone (_____)_____ Speaks English? o Yes o No

Cell Phone (_____)_____ If *no*, specify language_____

Parent/Guardian #2

Name_____ Relationship to student _____

Live in same home? o *Yes* o *No* If *no*, please complete the following: Home Phone (_____)_____

Home Address_____ Zip Code _____

City: o Bronx o Brooklyn o Manhattan o Queens o Staten Island Email _____

Work Phone (_____)_____ Speaks English? o Yes o No

Cell Phone (_____)_____ If *no*, specify language_____

RELEASE OF CHILD & EMERGENCY CONTACTS

A. I give my child permission to walk home alone at dismissal. o Yes o No

B. Does your child receive bussing? o Yes o No

C. I give 82nd Street Academics permission to obtain test results/grades which pertain to my child. o Yes o No

D. Does your child have an IEP? o Yes o No

My child will be picked up after-school by me or one of the following individuals:

1. Name_____ Relationship to student _____

Home Phone (_____)_____ Speaks English? o Yes o No

Work Phone (_____)_____ If not, specify language _____

Cell Phone (_____)_____

If the parent is unavailable, this person may be contacted in case of an emergency o Yes o No

2. Name_____ Relationship to student _____

Home Phone (_____)_____ Speaks English? o Yes o No

Work Phone (_____)_____ If not, specify language _____

Cell Phone (_____)_____

If the parent is unavailable, this person may be contacted in case of an emergency o Yes o No

3. Name_____ Relationship to student _____

Home Phone (_____)_____ Speaks English? o Yes o No

Work Phone (_____)_____ If not, specify language _____

Cell Phone (_____)_____

If the parent is unavailable, this person may be contacted in case of an emergency o Yes o No

o Yes, I have informed the persons above that they are listed as emergency contacts for my child

C. DO NOT RELEASE MY CHILD TO THE FOLLOWING PEOPLE:

Name_____ Relationship to student _____

Name_____ Relationship to student _____

PARENT/GUARDIAN SIGNATURE

I give my child permission to participate in all after-school program activities, including academic support, enrichment, social development, arts, sports, recreation, fitness and wellness. I understand that all program activities will be supervised by the community-based-organization providing the services. I agree that the professional staff of the after-school program may meet with my child and review my child's attendance, achievement and progress when appropriate.

_____

Parent/Guardian Signature Date

HEALTH RECORD

To be completed by the parent or guardian. This confidential health record will only be used to ensure the safety of the children in this program. **This program is not authorized to provide medication other than over-the-counter topical ointments.**
Feel free to continue your notes on back of this form.

Student's Name _____ Birth Date _____/_____/_____
Mo. Day Year

PLEASE PROVIDE YOUR CHILD'S MEDICAL HISTORY

Allergies to food	o Yes	oNo	Specify_____		
Behavioral/emotional issues	o Yes	oNo	Specify_____		
Individualized Education Plan	o Yes	oNo	Specify_____		
Physical Disabilities	o Yes	oNo	Specify_____		
Corrective Device	o Yes	o No	Specify (glasses, hearing aid, etc.)_____		
Asthma	o Yes	o No	Does your child use an inhaler?	o Yes	o No
Allergies to penicillin	o Yes	o No	Allergy to plants	o Yes	o No
Convulsions/seizures	o Yes	o No	Diabetes	o Yes	o No
Hay Fever	o Yes	o No	Allergy to insect stings	o Yes	o No

Other_____

_____

MEDICATION o Yes o No
Does your child take medication for any condition or illness? If yes, please describe below.

_____

_____

ACTIVITY PARTICIPATION o Yes o No
Are there any activities your child cannot participate in? If yes, please describe below.

_____

_____

SUNSCREEN AND TOPICAL OINTMENTS o Yes o No
Do you give permission to the after-school program to apply sunscreen or other over-the-counter topical ointments on your child?

HEALTH/INSURANCE INFORMATION

Student's Doctor: _____ Phone:(_____) _____

Insurance company: _____ Policy Holder's ID:_____

If my child requires emergency medical care and I cannot be reached, I give my consent to the above after-school program to obtain the necessary medical care for my child. I agree to pay all of the costs associated with the emergency medical care that my child receives. I understand that every effort will be made to contact me before and after medical care is provided. I understand that this consent will be in effect as of the date of my signing this form and will continue as long as my child is enrolled in this after-school program.

_____

Signature Date

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly Press Hard

STUDENT ID NUMBER OSIS

TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | **Sex** ☐ Female ☐ Male | **Date of Birth** *(Month/Day/Year)* __ __ / __ __ / __ __ __ __

Child's Address | **Hispanic/Latino?** ☐ Yes ☐ No | **Race** *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other _____

City/Borough | State | Zip Code | School/Center/Camp Name | District Number __ __ __ | **Phone Numbers** *Home* _____ *Cell* _____ *Work* _____

Health insurance (including Medicaid)? ☐ Yes ☐ No | ☐ **Parent/Guardian** Last Name | First Name | ☐ **Foster Parent**

TO BE COMPLETED BY HEALTH CARE PROVIDER *If "yes" to any item, please explain (attach addendum, if needed)*

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF/Asthma Action Plan):* ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Inhaled corticosteriod ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ **Other** *(specify)* _____

Explain all checked items above or on addendum

Medications *(attach MAF if in-school medication needed)*

☐ None ☐ Yes *(list below)*

_____

_____

Dietary Restrictions

☐ None ☐ Yes *(list below)*

_____

PHYSICAL EXAMINATION

Height _____ **cm** (__ __ %ile)

Weight _____ **kg** (__ __ %ile)

BMI _____ **kg/m²** (__ __ %ile)

Head Circumference *(age ≤2 yrs)* _____ **cm** (__ __ %ile)

Blood Pressure *(age ≥3 yrs)* _____ / _____

General Appearance:

	NI	Abnl		NI	Abnl		NI	Abnl		NI	Abnl		NI	Abnl
☐	☐	HEENT	☐	☐	Lymph nodes	☐	☐	Abdomen	☐	☐	Skin	☐	☐	Psychosocial Development
☐	☐	Dental	☐	☐	Lungs	☐	☐	Genitourinary	☐	☐	Neurological	☐	☐	Language
☐	☐	Neck	☐	☐	Cardiovascular	☐	☐	Extremities	☐	☐	Back/spine	☐	☐	Behavioral

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)* ☐ Within normal limits

If delay suspected, specify below

☐ Cognitive *(e.g., play skills)* _____

☐ Communication/Language _____

☐ Social/Emotional _____

☐ Adaptive/Self-Help _____

☐ Motor _____

SCREENING TESTS	*Date Done*	*Results*
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	__/__/__	_____ µg/dL
	__/__/__	_____ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	__/__/__	☐ At risk *(do BLL)* ☐ Not at risk
Hearing ☐ Pure tone audiometry ☐ OAE	__/__/__	☐ Normal ☐ Abnormal
Head Start Only		
Hemoglobin or Hematocrit *(age 9–12 mo)*	__/__/__	_____ g/dL _____ %

	Date Done	*Results*
Tuberculosis *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school*		
PPD/Mantoux *placed*	__/__/__	Induration _____mm
PPD/Mantoux *read*	__/__/__	☐ Neg ☐ Pos
Interferon Test	__/__/__	☐ Neg ☐ Pos
Chest x-ray *(if PPD or Interferon positive)*	__/__/__	☐ NI ☐ Abnl ☐ Not Indicated
Vision *(required for new school entrants and children age 4–7 yrs)*	__/__/__ ☐ with glasses	Acuity *Right* ___ / ___ *Left* ___ / ___ Strabismus ☐ No ☐ Yes

IMMUNIZATIONS – DATES CIR Number of Child

Hep B	__/__/__	__/__/__	__/__/__	__/__/__
Rotavirus	__/__/__	__/__/__	__/__/__	__/__/__
DTP/DTaP/DT	__/__/__	__/__/__	__/__/__	__/__/__
	__/__/__	__/__/__	__/__/__	__/__/__
Hib	__/__/__	__/__/__	__/__/__	__/__/__
PCV	__/__/__	__/__/__	__/__/__	__/__/__
Polio	__/__/__	__/__/__	__/__/__	__/__/__

Influenza	__/__/__	__/__/__	__/__/__	__/__/__
MMR	__/__/__	__/__/__	__/__/__	__/__/__
Varicella	__/__/__	__/__/__		
Td	__/__/__	__/__/__	__/__/__	__/__/__
Tdap __/__/__	Hep A	__/__/__	__/__/__	
Meningococcal	__/__/__	__/__/__		
HPV	__/__/__	__/__/__	__/__/__	
Other, *specify:* _____	__/__/__	_____	__/__/__	

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet

☐ Restrictions *(specify)* _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: __/__/__

Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision

☐ Other _____

ASSESSMENT ☐ **Well Child** (V20.2) ☐ **Diagnoses/Problems** *(list)* **ICD-9 Code**

_____ __ __ __ __

_____ __ __ __ __

_____ __ __ __ __

Health Care Provider Signature | Date __ __ / __ __ / __ __

Health Care Provider Name and Degree *(print)* | Provider License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (__ __ __) __ __ __ – __ __ __ __ | Fax (__ __ __) __ __ __ – __ __ __ __

DOHMH ONLY **PROVIDER I.D.**

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments

Date Reviewed: __/__/__ **I.D. NUMBER**

REVIEWER:

Copies: **White** School/Child Care/Early Intervention/Camp, **Canary** Health Care Provider, **Pink** Parent/Guardian