



GODDARD RIVERSIDE  
COMMUNITY CENTER

Beacon Program's

# Summer Day Camp

APPLICATION 2012

7-Week Summer Day Camp  
July 2-August 16  
Monday-Friday 8:00-5:00pm

Children Ages 11-13

## Enrollment Instructions 1-2-3

1. Complete the entire form before submitting it to the office, including the TANF and CACFP forms.
  - Faxed applications will not be accepted and incomplete forms will be returned.
  - Please sign and date all forms where indicated.
  - Communication is key! Be sure to provide accurate contact information and return information requests in a timely manner.
2. Medicals **MUST** be submitted before the first day of camp.
3. Once your application is received, you will be notified to attend the mandatory parent orientation in May.

### A Note on Attendance...

*Due to first week camp orientation and last week of final events, attendance is required especially during the first and last week of camp.*

For more information, please call (212) 866-0009 or email [mdavid@goddard.org](mailto:mdavid@goddard.org)





<b>Today's Date/ Fecha de hoy</b>		<b>To Be Completed By Staff Start Date:</b>	
<b>To Be Completed By Staff: Member ID</b>		<b>To Be Completed By Staff Group:</b>	
<b>PARTICIPANT INFORMATION/INFORMACIÓN DEL NIÑO</b>			
<i>Please check sessions:</i>		<input type="checkbox"/> Session 1: July 2 – July 27 <input type="checkbox"/> Session 2: July 30- August 16	
<i>Last Name/APELLIDO</i>		<i>First Name/Nombre</i>	<i>Middle/Inicial</i>
<i>Address/Dirección</i>		<i>Apt</i>	<i>NYCHA Resident</i> <input type="checkbox"/> Y <input type="checkbox"/> N
<i>City/Ciudad</i>		<i>State/Estao</i>	<i>Zip</i>
<i>Home Telephone/Teléfono de la casa</i> ( )		<i>Attended Summer 2011</i> <input type="checkbox"/> Y <input type="checkbox"/> N	
<i>Age/Edad</i>	<i>Gender/Sexo</i> <input type="checkbox"/> M <input type="checkbox"/> F	<i>Date of Birth/Fecha de nacimiento: (mm/dd/yy)</i>	
<i>Grade/Grado In September</i>	<i>School/Escuela</i>		<i>Type of School</i> <input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> Charter
<i>Primary Language Spoken</i>		<i>English Proficient</i> <input type="checkbox"/> Y <input type="checkbox"/> N	<i>Other Languages Spoken</i>
<i>Ethnicity/Etnicidad</i>	<input type="checkbox"/> American Indian/Americano native <input type="checkbox"/> African-American/Black (Non-Hispanic) <input type="checkbox"/> White/Blanco (Non-Hispanic) <input type="checkbox"/> Pacific Islander		<input type="checkbox"/> Asian/Asiático <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Other/Otro/Multi-Race
<i>Other GRCC Programs Attended</i>	<input type="checkbox"/> Day Care <input type="checkbox"/> BWC After School <input type="checkbox"/> BWC Summer Camp <input type="checkbox"/> Head Start <input type="checkbox"/> W84th Street After School <input type="checkbox"/> W84th Street Summer Camp <input type="checkbox"/> OPTIONS <input type="checkbox"/> Beacon <input type="checkbox"/> Softball <input type="checkbox"/> Swimming		
<i>Where did you learn about this program?</i>	<input type="checkbox"/> Previous Member <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Flyer <input type="checkbox"/> Website <input type="checkbox"/> Email <input type="checkbox"/> Newspaper <input type="checkbox"/> Magazine <input type="checkbox"/> School <input type="checkbox"/> Church <input type="checkbox"/> Other _____		
<i>Has the participant been enrolled in any of the following?</i> <input type="checkbox"/> ACS <input type="checkbox"/> OST <input type="checkbox"/> TASC <input type="checkbox"/> Service Learning			

154 West 93<sup>rd</sup> Street, NY, NY 10025  
(212) 866-0009 Fax (212) 666-3054 Email: jdavis@goddard.org





Youth's Last Name/ Apellido		Youth's First Name/ Nombre	
<b>PARENT/GUARDIAN INFORMATION/INFORMACION DEL PADRE/GUARDIAN</b>			
<b>Parent/Guardian/1</b>			
Last Name/Apellido		First Name/Nombre	Middle/Inicial
Telephone/Teléfono ( )		Business/Other Telephone/Teléfono del trabajo ( )	
Cell/Other Telephone ( )		Email Address	
Relationship/Relación	Primary Language Spoken	English Proficient [ ] Y [ ] N	Other Languages Spoken
Are you a registered voter?/¿Usted esta registrado para votar? [ ] Y [ ] N			
<b>Parent/Guardian/2</b>			
Last Name/Apellido		First Name/Nombre	Middle/ Inicial
Telephone/Teléfono ( )		Business/Other Telephone/Teléfono del trabajo ( )	
Cell/Other Telephone ( )		Email Address	
Relationship/Relación	Primary Language Spoken	English Proficient [ ] Y [ ] N	Other Languages Spoken
<b>HOUSEHOLD INFORMATION</b>			
Household Type [ ] Single Parent-Female [ ] Single Parent-Male [ ] Two Parents [ ] Grandparent(s) [ ] Other			
Number in Household [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 or more			
Income/Ingreso [ ] Employment [ ] SSI/SSD [ ] Public Benefits [ ] Unemployment [ ] Retirement [ ] No Income [ ] Other			
Are you or any member of your household (0-65 years of age) covered by Medicaid, Child Health Plus, Family Health Plus or private medical insurance? [ ] Y [ ] N			
Are any other members of the household involved in GRCC programs? [ ] Y [ ] N	If yes which programs? [ ] Beacon After School [ ] BWC After School [ ] Head Start [ ] Day Care [ ] Beacon Evening [ ] BWC Summer Camp [ ] Softball [ ] Swimming [ ] Beacon Summer Day Camp [ ] W84th Street After School [ ] OPTIONS [ ] W84th Street Summer Camp [ ] Senior Center [ ] Other		



<i>Youth's Last Name/ Apellido</i>		<i>Youth's First Name/ Nombre</i>	
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**EMERGENCY CONTACTS & DISMISSAL AUTHORIZATION /  
CONTACTOS DE EMERGENCIA Y AUTORIZACIÓN PARA RECOGER A LOS NIÑOS**

*Please provide us with a list of additional names and telephone numbers of alternate persons whom we may contact in case of emergency. Designate any of these people as authorize to pick up your child by checking the box beside their name.*

<i>Last Name/Appellido</i>	<i>First Name/Nombre</i>	<i>Telephone/Telefono</i>	<i>Relationship/ Relación</i>	<i>Pick Up</i>
		( )		[ ]
		( )		[ ]
		( )		[ ]

*Please list any additional people, family members and friends, not listed above who you authorize to pick up your child from the program. Parent/Guardian1 is automatically included as an authorized person.*

[ ] *I give permission for my child to walk home alone/Yo autorize a que mi hijo/a a casa.*

<i>Last Name/ Apellido</i>	<i>First Name/Nombre</i>	<i>Telephone/ Teléfono</i>	<i>Relationship/ Relación</i>
		( )	
		( )	
		( )	
		( )	
		( )	

[ ] **Child may not be picked up by/El niño no puede ser recogido por:**

<i>Last Name/ Apellido</i>	<i>First Name/Nombre</i>	<i>Relationship/ Relación</i>



<i>Youth's Last Name/ Apellido</i>		<i>Youth's First Name/ Nombre</i>	
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**PARENT/GUARDIAN CERTIFICATION & AGREEMENT**

As a condition of registration of my child in the Beacon Summer Day Camp Program at **GODDARD RIVERSIDE COMMUNITY CENTER (CENTER)**, I agree to the following:

All of the given information on registration contract is correct. I will follow program rules and regulations. I hereby make a commitment to have my child attend the Beacon Summer Day Camp on a regular basis for the period enrolled. **IN CASE OF CANCELLATION, PLEASE NOTIFY THE BEACON OFFICE UP TO 5 DAYS PRIOR TO THE START OF THE DAY CAMP SESSION.** I understand that my child may be dismissed from the program because of inconsistent attendance or absence from the program for more than three (3) consecutive days without prior notice. I will, to the best of my ability, support my child's participation and development and will communicate with the CENTER to accomplish these goals.

**PARTICIPATION.** I agree to participate in Parent Activities including attending meetings, volunteering or contributing to special events.

**TRIP PERMISSION.** I hereby give my child permission to take all trips and participate in all events with the CENTER during regular program hours, (8:00 a.m. – 6:00 p.m.), within the New York City/Tri State area. Trip calendars will be available the first day of camp.

**WAIVER.** I hereby authorize **Goddard Riverside Community Center** to photograph and record, both digital and analog, my child for any and all purposes in connection with **Goddard Riverside Community Center**. I agree to hold **Goddard Riverside Community Center** harmless from any liability arising out of photographs, digital images, videos and recordings and waive any compensation for pictures, printed works or audio/visual products of or by my child. These images and videos may also be used by the New York City Department of Youth and Community Development (**DYCD**) in its publications.

**MEDICAL AUTHORIZATION.** In the event of an emergency, and after every attempt has been made to contact me, I hereby give permission for the agency, **Goddard Riverside Community Center**, to get medical treatment for my child. I further authorize the doctor or the hospital to which my child may be brought and whomever they may designate as their assistant, to perform any emergency procedure or operation on my child during their attendance in **the Goddard Riverside Community Center** program.

\_\_\_\_\_  
Parent/Guardian Signature/ Firma del Padre/Guardián

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date/Fecha

# TANF YOUTH SERVICES APPLICATION

The information requested on this form is necessary to determine whether or not federal Temporary Assistance for Needy Families (TANF) funds may be used to provide services to you. This application form may be used by an applicant for services who is under 21 years of age.

## SECTION ONE

### A. Information About the Youth Applicant

1. Applicant's Name: \_\_\_\_\_

Home Address: \_\_\_\_\_  
(street) (apartment number)

\_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip code)

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(month, day, year)

Telephone Number: \_\_\_\_\_

## SECTION TWO Citizen / Non-Citizen Status

A. Are you a United States citizen?

**Yes.** If yes, go to Section Three.

**No.** If no, complete Item B.

B. If you (the youth applicant) are not a United States citizen, look at the "Immigration Status List" on pages 5 and 6 and tell us which status applies to you. Enter the status number from the list and complete the information below.

Immigration status (# 1 through 15) that applies: \_\_\_\_\_

INS Form Number: \_\_\_\_\_

Alien Number: \_\_\_\_\_

Date of Entry into United States: \_\_\_\_\_

## SECTION THREE Income of Family Members

A. Do you (the youth applicant) currently receive benefits under one or more of these programs?

**Yes,** check which program(s) and then go to Section Four.

FAMILY ASSISTANCE/ SAFETY NET	MEDICAID	FOOD STAMPS	HEAP	SSI	SCHOOL LUNCH

No, complete Item B, on page 2.

**B. If you do not currently receive one of the programs listed above, please tell us about any income of your family members.**

Include the gross income (income before taxes and deductions) of each family member who lives with you. Family members include your mother, father, stepmother, stepfather, any brothers or sisters (including half-siblings) who are under 18 years of age (or 18 and in secondary school) and these siblings' parents. If you have a child of your own, you should include that child, any brothers or sisters of the child, and the child's parent. You should not include any of these people if they do not live with you. You should not include other family members such as grandparents, uncles or aunts. If you are married, you should include your spouse, but do not need to include your parents or siblings.

List all sources of gross income, including wages, social security benefits, public assistance benefits, child support, alimony, etc. received and any other recurring income of a family member. You do not need to include any earned income (wages) received by you or any other family member who is under 18 years of age (or 18 and in secondary school) but must include any unearned income.

	NAME	INCOME SOURCE: WAGES, SOCIAL SECURITY, etc.	AMOUNT	RECEIVED (Check One)		
				Yearly	Monthly	Weekly
1.						
2.						
3.						
4.						
5.						
6.						

**SECTION FOUR Applicant Notification and Signature**

The individual signing this application may be asked to prove any or all of your statements. If we ask you to do this, we will tell you how to prove your statements.

We are asking for Social Security number(s) because any person applying for or receiving federal TANF services must give us his or her Social Security number; Social Security numbers are required under federal law (Section 409(a)(4) of the Social Security Act) and federal regulations (45 CFR 264.10). We may use Social Security number(s) to do computer matches with other programs to prove you are receiving these programs (for example, food stamps), to do a computer match to verify other information on the application, or to verify your alien status.

If you disagree with any decisions we make regarding your eligibility to receive TANF services, you may have your certification reviewed by a person at a level above the person who made the first decision.

**By signing this, I am swearing, under penalty of perjury, that all of the above statements are true to the best of my knowledge and that I am willing to cooperate with any efforts to verify the information provided.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

If the applicant lives with his or her parents, a parent or other adult relative caretaker must sign this form for the application to be complete. The Commissioner of the Department of Social Services or his or her designee must sign for children in foster care.

See INSTRUCTIONS on reverse.

**DAY CARE CENTER NAME:** Goddard Riverside Community Center

Print the name of the child(ren) enrolled in Day Care: @ BEACON

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**DIRECTIONS:**

**Complete SECTION A if your household:**

1. Receives Temporary Assistance to Needy Families (TANF)
2. Receives Food Stamps
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR)
4. Currently has a foster child enrolled in day care

**Complete SECTION B if Section A does not apply:**

Sign, date and indicate the Social Security number of the adult signing the certification and return the completed form to the day care center.

SECTION A	SECTION B															
TANF Number _____ Food Stamp Case Number _____ FDPIR Number _____ Foster Child's Name _____ Foster Child's Personal Monthly Income \$ _____ <p><b>An adult household member must sign the application before it can be approved.</b> After reading the following statement and the statement on the back, sign below.</p> <p>I certify that the above information is true and correct and that all income is reported. I understand this information is being given for the receipt of Federal funds, that officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.</p> Signature: _____ Date: _____	<p>List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received <b>last month</b> in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, welfare payments, child support and any other sources of income.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;">Name of Household Members</th> <th style="width: 30%;">Monthly Gross Income</th> </tr> </thead> <tbody> <tr><td>1. _____</td><td>\$ _____</td></tr> <tr><td>2. _____</td><td>\$ _____</td></tr> <tr><td>3. _____</td><td>\$ _____</td></tr> <tr><td>4. _____</td><td>\$ _____</td></tr> <tr><td>5. _____</td><td>\$ _____</td></tr> <tr><td>6. _____</td><td>\$ _____</td></tr> </tbody> </table> <p><b>An adult household member must sign the application before it can be approved.</b> After reading the following statement and the statement on the back, sign below.</p> <p>I certify that the above information is true and correct and that all income is reported. I understand this information is being given for the receipt of Federal funds, that officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.</p> Signature: _____ Print Name: _____ SS# _____ Date: _____		Name of Household Members	Monthly Gross Income	1. _____	\$ _____	2. _____	\$ _____	3. _____	\$ _____	4. _____	\$ _____	5. _____	\$ _____	6. _____	\$ _____
Name of Household Members	Monthly Gross Income															
1. _____	\$ _____															
2. _____	\$ _____															
3. _____	\$ _____															
4. _____	\$ _____															
5. _____	\$ _____															
6. _____	\$ _____															
<b>FOR SPONSOR USE ONLY</b>																
Sponsor Agreement Number _____ Total Household Members _____ Total Income \$ _____ Free _____ Reduced _____ Paid _____ Signature of Determining Official _____ Date Determined ____/____/____																

## Section 9

Unless you list the child's food stamp, FDPIR or TANF case number or are applying for a foster child, Section 9 of the National School Lunch Act requires that you include the social security number of the household member signing the application or indicate that the household member signing the application does not have a social security number. You do not have to list a social security number, but if a social security number is not listed or an indication is not made that the adult household member signing the application does not have a social security number, we cannot approve the application. The social security number may be used to identify the household member in verifying the correctness of the information stated on the application. This may include program reviews, audits and investigations and may include contacting employers to determine income, contacting a food stamp, FDPIR or TANF office to determine current certification for food stamps, FDPIR or TANF benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims or legal actions if incorrect information is reported.

### Definition of Income

"Income" means income before deductions for income taxes, social security taxes, insurance premiums, charitable contributions, and bonds, etc. It includes the following: (1) monetary compensation for services, including wages, salary, commissions or fees; (2) net income from non-farm self-employment; (3) net income from farm self-employment; (4) social security payments; (5) dividends or interest on savings or bonds, income from estates or trusts or net rental income; (6) public assistance or welfare payments; (7) unemployment compensation; (8) government civilian employee or military retirement, or pensions or veteran's payments; (9) private pensions or annuities; (10) alimony or child support payments; (11) regular contributions from persons not living in the household; (12) net royalties; (13) military benefits received in cash, such as housing allowance; and (14) any other cash income.

### Definition of Household

Household means "family" as defined in Section 226.2. "Family" means a group of related or non-related individuals who are not residents of an institution or boarding house, but who are living as one economic unit.

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## INSTRUCTIONS FOR COMPLETING DOH-3688

### Instructions for Parents or Guardians:

Write in the name of the day care center in the space provided.

Print the name of each child in your household who attends this day care center.

**Section A:** If your household receives Temporary Assistance for Needy Families (TANF) or Food Stamps or participates in the Food Distribution Program on Indian Reservations (FDPIR), complete Section A only. Write down the TANF, FS or FDPIR number (do not use your ACD or DSS child care subsidy number) and sign and date the form and return it to the day care center.

**Foster children:** If your household includes a foster child who is in day care, complete Section A only. Write in the foster child's name and any income that the child receives from social services for his or her personal use. Write in "0" if the foster child does not receive any income. A separate application must be completed for each foster child. The foster parent or an official who represents the child must sign and date the form and then return it to the day care center.

**Section B:** Write in the names of all the people living in your household, even if they do not have any income. Include yourself and all other adults and children in the household, including unrelated people. Do not include the children in day care, who are listed at the top of the form.

Enter the amount of income each person received **last month**, before taxes or anything else was taken out. Refer to the Definition of Income and the Definition of Household on the reverse side of the application. If any amount last month was more or less than the usual, write in that person's usual income. The signature and social security number of the adult signing the certification is required. If you do not have a social security number, write "none".

### Instructions for Centers and Sponsors

The "For Sponsor Use Only" section is to be completed, signed and dated by day care center or sponsor staff.

The sponsor/center representative must review the income eligibility application and ensure that it is completed as indicated in the instructions above. Then indicate the following:

**The sponsor agreement number.**

**Total household members** – This item does not have to be completed if the parent completed Section A. Add those indicated in Section B (if completed) to the children enrolled in day care.

**Total Income** – This item does not need to be completed if the parent completed Section A. Indicate the total monthly income as calculated from Section B. If the parent chooses not to disclose income, the application must be categorized as "paid."

**Free, Reduced or Paid** – Compare the total household income and the total number of household members with the current year's Income Eligibility Guidelines (DOH-3687) to determine if the household should be categorized as **Free, Reduced or Paid**. Use the appropriate column on the DOH-3687 to categorize their income. For example, if the parent indicated biweekly income, multiply this amount by 2.15 to determine monthly income, or by 26 to determine yearly income.

Incomplete applications (missing signatures, income information, social security numbers, TANF FDPIR or Food Stamp numbers) are categorized in the paid category.

**The income eligibility application is valid for one calendar year only.**

# 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 **Goddard Riverside Community Center** District Number \_\_\_\_\_ Phone Numbers  
Home \_\_\_\_\_  
Cell \_\_\_\_\_  
Work \_\_\_\_\_  
Health insurance:  Yes  Parent/Guardian Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
 No  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 corticosteroid  Other controller  Quick relief med  Oral steroid  None  
 Attention Deficit Hyperactivity Disorder  Orthopedic Injury/disability  
 Chronic or recurrent otitis media  Seizure disorder  
 Congenital or acquired heart disorder  Speech, hearing, or visual impairment  
 Developmental/learning problem  Tuberculosis (latent infection or disease)  
 Diabetes (attach MAF)  Other (specify) \_\_\_\_\_

**Medications (attach MAF if in-school medication needed)**  
 None  Yes (list below) \_\_\_\_\_

**Dietary Restrictions**  
 None  Yes (list below) \_\_\_\_\_

*Explain all checked items above or on addendum*

**PHYSICAL EXAMINATION**  
Height \_\_\_\_\_ cm (\_\_\_\_\_%ile)  
Weight \_\_\_\_\_ kg (\_\_\_\_\_%ile)  
BMI \_\_\_\_\_ kg/m<sup>2</sup> (\_\_\_\_\_%ile)  
Head Circumference (age ≤2 yrs) \_\_\_\_\_ cm (\_\_\_\_\_%ile)  
Blood Pressure (age ≥3 yrs) \_\_\_\_\_ / \_\_\_\_\_

**General Appearance:**

<input type="checkbox"/> NI Abnl	<input type="checkbox"/> HEENT	<input type="checkbox"/> NI Abnl	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> NI Abnl	<input type="checkbox"/> Abdomen	<input type="checkbox"/> NI Abnl	<input type="checkbox"/> Skin	<input type="checkbox"/> NI Abnl	<input type="checkbox"/> Psychosocial Development
<input type="checkbox"/>	<input type="checkbox"/> Dental	<input type="checkbox"/>	<input type="checkbox"/> Lungs	<input type="checkbox"/>	<input type="checkbox"/> Genitourinary	<input type="checkbox"/>	<input type="checkbox"/> Neurological	<input type="checkbox"/>	<input type="checkbox"/> Language
<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/> Extremities	<input type="checkbox"/>	<input type="checkbox"/> Back/spine	<input type="checkbox"/>	<input type="checkbox"/> Behavioral

**Describe abnormalities:** \_\_\_\_\_

DEVELOPMENTAL (age 0-6 yrs) <input type="checkbox"/> Within normal limits	SCREENING TESTS	Date Done	Results
If delay suspected, specify below <input type="checkbox"/> Cognitive (e.g., play skills) _____ <input type="checkbox"/> Communication/Language _____ <input type="checkbox"/> Social/Emotional _____ <input type="checkbox"/> Adaptive/Self-Help _____ <input type="checkbox"/> Motor _____	<b>Blood Lead Level (BLL)</b> (required at age 1 yr and 2 yrs and for those at risk)	____/____/____	____ µg/dL
	<b>Lead Risk Assessment</b> (annually, age 6 mo-6 yrs)	____/____/____	<input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk
	<b>Hearing</b> <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE	____/____/____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
	<b>Hemoglobin or Hematocrit (age 9-12 mo)</b>	____/____/____	____ g/dL ____ %
	<b>Head Start Only</b>		
	<b>Tuberculosis</b> <i>Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school</i>	<b>Date Done</b>	<b>Results</b>
	PPD/Mantoux placed	____/____/____	induration _____ mm <input type="checkbox"/> Neg <input type="checkbox"/> Pos
	PPD/Mantoux read	____/____/____	<input type="checkbox"/> Neg <input type="checkbox"/> Pos
	Interferon Test	____/____/____	<input type="checkbox"/> Neg <input type="checkbox"/> Pos
	Chest x-ray (if PPD or interferon positive)	____/____/____	<input type="checkbox"/> NI <input type="checkbox"/> Not Indicated <input type="checkbox"/> Abnl
	<b>Vision</b> (required for new school entrants and children age 4-7 yrs)	____/____/____	Acuity Right _____ / _____ Left _____ / _____ <input type="checkbox"/> with glasses Strabismus <input type="checkbox"/> No <input type="checkbox"/> 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 \_\_\_\_\_ Appl. 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 PROVIDER ONLY** ID:

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

Comments \_\_\_\_\_

Date Reviewed: \_\_\_\_\_ I.D. NUMBER:

REVIEWER: \_\_\_\_\_