

Goddard Riverside

INVESTING IN PEOPLE, STRENGTHENING COMMUNITY

August 2019

Dear Parents/Guardians:

We are pleased to announce registration for the After School Program 2019-2020 at the Bernie Wohl Center for children in **grades K-5**. The After School Program will operate from **September 9, 2019 through May 29, 2020**, Monday – Friday, 3:00pm to 6:00pm on regular school days.

Registration begins on Monday, August 12. You must make an appointment to register. You can pick up an application at the Bernie Wohl Center (647 Columbus Avenue). Forms will also be available for download from our website <http://www.goddard.org>. Program fees are based on family income and supporting documentation. A non-refundable registration fee of \$50.00 is due at time of registration. ***Payments must be completed by January 31, 2020. We accept approved ACS/HRA Vouchers.***

There is a 10% discount (with a 20% max) for the following:

- NYCHA Residents
- After School Program Participant 2018-2019
- Summer Day Camp 2019 Participant
- Goddard Riverside Early Childhood recent participant (Fall 2018/Spring 2019/Summer 2019)
- A sibling registered for After School Program BWC

We will have escort service from the following schools at no additional cost:

- PS 9, PS 75, PS 84, PS 163, PS 166 and PS 333 (MSC)

The following will be needed to complete registration:

- **Registration fee of \$50.00 (non-refundable and credited towards total fee)**
- **Registration Contract**
- **Income Eligibility Form (CACFP Snack, not needed if completed for summer 2019)**
- Request for Tutoring Form at the Star Learning Center for Grades 2-5 (Optional)
- Health Examination Form (current within 1 year)
- Copy of most recent report card or school progress report
- **Proof of Income (2018 W-2 or 3 recent pay stubs (within 2018) or Budget Letter, not needed if completed for summer 2019)**
- Attendance at Parents' Orientation in late September - Date TBA

If you have questions, please contact us at 212-799-9400 or dnoyola@goddard.org or ycastillo@goddard.org.

We also provide full day services (Holiday Camp) from 8:00am to 6:00pm during the public school mid-winter and spring recesses. Additional fees apply for these services.

*****Contact our Beacon office at (212) 866-0009 (summer phone number is 646-784-8449) for registration and information about the After School Program for Middle School youth in grades 6-8 and about High School and Adult programming.***

*****Contact Lincoln Square for additional After School Programming for children in grades K-6 at (212) 874-0860.***

Goddard Riverside

INVESTING IN PEOPLE. STRENGTHENING COMMUNITY

Agosto 2019

Estimados padres / tutores:

Nos complace anunciar el registro para el Programa Después de la Escuela 2019-2020 en el Centro Bernie Wohl para niños en los grados K-5. **El Programa Después de la Escuela operará desde el 9 de septiembre de 2019 hasta el 29 de mayo de 2020**, de lunes a viernes, de 3:00 pm a 6:00 pm en los días escolares regulares.

La inscripción comienza el lunes 12 de agosto. Debe hacer una cita para registrarse. Puede recoger una solicitud en el Centro Bernie Wohl (647 Columbus Avenue). Los formularios también estarán disponibles para descargar desde nuestro sitio web <http://www.goddard.org>. Las tarifas del programa se basan en el ingreso familiar y la documentación de respaldo. Se debe pagar una cuota de inscripción no reembolsable de \$ 50.00 al momento de la inscripción. **Los pagos deben completarse antes del 31 de enero de 2020.** Aceptamos los vales aprobados de ACS / HRA.

Hay un descuento del 10% (con un máximo del 20%) para lo siguiente:

- Residentes de NYCHA
- Participante del programa después de la escuela 2018-2019
- Summer Day Camp 2019 Participante
- Participante reciente de Goddard Riverside Early Childhood (otoño de 2018 / primavera de 2019 / verano de 2019)
- Un hermano registrado en el Programa Después de la Escuela BWC

Tendremos servicio de escolta de las siguientes escuelas sin costo adicional:

- PS 9, PS 75, PS 84, PS 163, PS 166 y PS 333 (MSC)

Se necesitará lo siguiente para completar el registro:

- **Cuota de inscripción de \$ 50.00 (no reembolsable y acreditada como tarifa total)**
- **Contrato de Registro**
- **Formulario de elegibilidad de ingresos (CACFP Snack, no es necesario si se completa para el verano de 2019)**
- Solicitud de formulario de tutoría en el Star Learning Center para los grados 2-5 (opcional)
- Formulario de examen de salud (vigente dentro de 1 año)
- Copia de la boleta de calificaciones más reciente o informe de progreso escolar
- Prueba de ingresos (2018 W-2 o 3 talones de pago recientes (dentro de 2018) o Carta de presupuesto, no se necesita si se completa para el verano de 2019)
- Asistencia a la Orientación de los Padres a finales de septiembre - Fecha TBA

Si tiene alguna pregunta, contáctenos al 212-799-9400 o dnoyola@goddard.org o ycastillo@goddard.org.


También brindamos servicios de día completo (Campamento de vacaciones) de 8:00 a.m. a 6:00 p. M. Durante los recreos de mediados de invierno y primavera de las escuelas públicas. Se aplican tarifas adicionales por estos servicios. **** Comuníquese con nuestra oficina de Beacon al (212) 866-0009 (el número telefónico de verano es 646-784-8449) para inscribirse e información sobre el Programa Después de la Escuela para jóvenes de secundaria en los grados 6-8 y sobre la programación de la Escuela Secundaria y de Adultos. ** Comuníquese con Lincoln Square para obtener información adicional sobre la programación después de la escuela para niños en los grados K-6 al (212) 874-0860.**

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AFTER SCHOOL PROGRAM/BWC
REGISTRATION CONTRACT 2019-2020/
PROGRAMMA DEPUES DE LA ESCUELA/BWC
CONTRATO DE REGISTRO 2019-2020

STAFF COMPLETES					
Registration Date/ Fecha de hoy				Group/Activity/ Member ID	
PARTICIPANT INFORMATION/INFORMACIÓN DEL PARTICIPANTE					
Last Name/ Apellido			First Name, Middle/ Nombre, Inicial		
Home Address/ Dirección					Apt/ Apto
City/Ciudad		<input type="checkbox"/> Manhattan <input type="checkbox"/> Queens <input type="checkbox"/> Bronx <input type="checkbox"/> Brooklyn <input type="checkbox"/> Staten Island <input type="checkbox"/> _____			
State/Estao		<input type="checkbox"/> NY <input type="checkbox"/> NJ <input type="checkbox"/> _____		Zip Code/ Codigo Postal	
Primary Telephone/Teléfono Primario					
Housing/Vivienda		<input type="checkbox"/> Rental/Alquiler <input type="checkbox"/> NYCHA Housing/Proyectos NYCHA <input type="checkbox"/> Family Owned/ Propiedad Familiar <input type="checkbox"/> Other/Otro			
Age/ Edad	Gender/ Sexo	<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Gender Nonconforming		Date of Birth/ Fecha de nacimiento (mm/dd/yyyy)	
Current Grade/Grado		<input type="checkbox"/> K <input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd <input type="checkbox"/> 4th <input type="checkbox"/> 5th		School/ Escuela	
School Type/Tipo de Escuela		<input type="checkbox"/> Public/Publica <input type="checkbox"/> Charter/Carta <input type="checkbox"/> Private/Privada <input type="checkbox"/> Other/Otro			
Class/Room		Teacher's Names/ Nombre de la Maestra(o)			
Does Child have an IEP?		<input type="checkbox"/> Y <input type="checkbox"/> N		Does Child have a 504 Plan?	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
Race/Raza (Select all that Apply) (Seleccione todas las que correspondan)		<input type="checkbox"/> American Indian and Alaskan Native/Indio Americano y Nativo de Alaska <input type="checkbox"/> Asian/Asiático <input type="checkbox"/> Black/African-American/Afroamericano <input type="checkbox"/> Native Hawaiian and Pacific Islander/Hawaiano Nativo/Isleño Pacificas <input type="checkbox"/> White/Caucasian/Blanco <input type="checkbox"/> Other/Otro			
Ethnicity/Etnicidad		<input type="checkbox"/> Hispanic/Latino(a) <input type="checkbox"/> Not Hispanic/No Latino(a)			
Any Medical Conditions/Allergies/ Alguna condición medica/Alergias		<input type="checkbox"/> Y <input type="checkbox"/> N		If yes explain/ Si es si porfavor de explicar	


<p>Goddard Riverside Community Center / Bernie Wohl Center 647 Columbus Avenue, NY, NY 10025 (212) 799-9400 Fax (212) 875-9400 dnoyola@goddard.org * ycastillo@goddard.org</p>	
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AFTER SCHOOL PROGRAM/BWC
REGISTRATION CONTRACT 2019-2020/
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CONTRATO DE REGISTRO 2019-2020

Youth's Last Name/Apellido		Youth's First Name/Nombre	
PARENT/GUARDIAN INFORMATION/INFORMACION DEL PADRE/GUARDIAN			
Primary Parent/Guardian			
Last Name/Apellido		First Name/Nombre	
Relationship/Relación			
Primary Telephone/Teléfono Primario			
Secondary Telephone/Teléfono Secundario			
Email Address/Coreo Electronico			
Primary Language Spoken/Lenguaje Primario			
Are you a registered voter? /¿Usted esta registrado para votar?			<input type="checkbox"/> Y <input type="checkbox"/> N
Are you or any member of your household (0-64 years of age) covered by Medicaid, Child Health Plus, Family Health Plus or private medical insurance? / ¿Usted o algún miembro de su familia (de 0-64 años) tienen el seguro de Medicaid, Child Health Plus, Family Health Plus o seguro médico privado?			<input type="checkbox"/> Y <input type="checkbox"/> N
Additional Contact			
Last Name/Apellido		First Name/Nombre	
Relationship/Relación			
Primary Telephone/Teléfono Primario			
Secondary Telephone/Teléfono Secundario			
Email Address/ Coreo Electronico			

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 CONTRATO DE REGISTRO 2019-2020

Youth's Last Name/Apellido	Youth's First Name/ Nombre
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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 will notify Goddard Riverside Community Center if there are any changes in the persons named in emergency contacts and dismissal authorizations **Parent/Guardian is automatically included as an authorized person. Authorized escorts under 14 old years of age will be allowed at the Program's discretion. /**

Por favor provenos con una lista de nombres y telefonos de personas que podemos llamar en caso de emergencia y que pueden recoger a su hijo(a) del programa. Yo notificaré a Goddard Riverside Community Center si hay cambios en los nombres de las personas que estan en los contactos de emergencia y autorización de partida. **Padres/Guardianes están automáticamente incluidos como personas autorizadas. Escortas autorizadas menos de 14 años de edad serán permitidos a la discreción del programa.**

Last Name/Appellido	First Name/Nombre	Telephone/Telefono	Relationship/Relación	Pick Up/Recojer
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>

I give permission for my child to walk home alone. / Yo autorizo a que mi hijo/a camine solo a su casa.


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

Last Name/ Apellido	First Name/Nombre	Relationship/ Relación

Goddard Riverside Community Center / Bernie Wohl Center
 647 Columbus Avenue, NY, NY 10025
 (212) 799-9400 Fax (212) 875-9400
dnoyola@goddard.org * ycastillo@goddard.org



Youth's Last Name/Apellido	Youth's First Name/Nombre
PARENT/GUARDIAN CERTIFICATION & AGREEMENT/ CERTIFICACIÓN Y ACUERDO DEL PADRE O GUARDIÁN	
As a condition of registration of my child in the PROGRAM of GODDARD RIVERSIDE COMMUNITY CENTER (CENTER) , I agree to the following:/Como condición del registro de mi hijo(a) en el PROGRAMA en GODDARD RIVERSIDE COMMUNITY CENTER , yo convengo lo siguiente:	
All the given information on registration contract is correct. I will follow program rules and regulations including making adequate arrangements to have young children picked up at dismissal time. 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. /Toda la información en el contrato de registraci3n esta corecta. Yo entiendo las reglas y polizas y voy a hacer lo mejor posible para recoger a mi hijo(a) a tiempo al la hora de partida del programa. Yo voy hacer lo mejor posible para apoyar a mi hijo(a) durante su participaci3n en le programa.	
<u>PARTICIPATION/ PARTICIPACI3N:</u> I agree to participate in Parent/Family Events including attending meetings, volunteering or contributing to special events. /Yo participar3 en las Actividades de los Padres lo cual incluye reuniones, ser voluntario o contribuir a evento especiales.	
<u>TRIP PERMISSION/ PERMISO PARA PASEOS:</u> I hereby give my child permission to participate in all program activities, field trips, sports, arts, recreation and events with the CENTER during regular program hours, within the New York City/Tri State area. /Yo doy permiso para que mi hijo(a) valla a los paseos con el programa durante las horas regulares.	
<u>WAIVER/ RENUNCIA:</u> I hereby authorize Goddard Riverside Community Center and DYCD or any of its designees to photograph and record, both digital and analog, my child for any and all purposes in connection with Goddard Riverside Community Center and DYCD . I agree to hold Goddard Riverside Community Center and DYCD 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. /Yo autoriz3 a Goddard Riverside Community Center y DYCD que retrat3 o grabe a mi hijo(a) para todo los propositos en conexi3n a Goddard Riverside Community Center . Estoy de aguerdo con mantener a Goddard Riverside Community Center y DYCD libre de toda responsabilidad que pueda surgir de las fotografias, imagenes, videos y grabaciones de mi hijo(a).	
<u>MEDICAL AUTHORIZATION/ AUTORIZACI3N MEDICA:</u> 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. /En el evento de una emergencia, y despu3 de que todos los medios de comunicarse conmigo sean agotados, yo le doy permiso a la agencia de Goddard Riverside Community Center de obtener atenci3n medica para mi hijo(a). Adem3s autorizo al medico y al hospital que pueden hacer qualquier procedimiento de emergencia o cirugia durante su asistencia en Goddard Riverside Community Center .	
_____ Parent/Guardian Signature/ Firma del Padre/Guardián	_____/_____/_____ Date/Fecha

<p style="text-align: center;"> Goddard Riverside Community Center / Bernie Wohl Center 647 Columbus Avenue, NY, NY 10025 (212) 799-9400 Fax (212) 875-9400 dnoyola@goddard.org * ycastillo@goddard.org </p>	
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<i>Youth's Last Name/Apellido</i>	<i>Youth's First Name/Nombre</i>
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INFORMED CONSENT/ CONSENTIMIENTO INFORMADO

Purpose/ Proposito: Each year to assure that the Goddard Riverside Summer Day Camp/After School Programs is of high quality and has a positive impact on your child(ren), Goddard Riverside Community Center engages in ongoing evaluation and quality improvement efforts. Therefore, all children enrolled in the program may potentially be asked to complete a survey at the beginning and end of each program cycle. / Cada año, para asegurar the After School Program at the Bernie Wohl Center sea de alta calidad y tenga un impacto positivo para sus niños, el Centro Comunitario Goddard Riverside se esfuerza a participar en evaluaciones y mejoramieto de calidad. De este modo, potencialmente les pediriamos a todos los participantes registrados en el program llenar una encuesta al principio y al final de cada ciclo del programa.

Procedures/ Procedimiento: Goddard Riverside Community Center is participating in the *Alorhythm Socio Emotional Learning Survey*. Data will be gathered and analyzed through a web-based software – *Alorhythm's Youth Development Impact Learning System (YD iLearning System)*; each child will be assigned a unique identifier. Alorhythm's YD iLearning System will never use a child's name for any reason and all data analyzed through this system will be presented as group results. Staff within the Programs will have access to the data so that they can continue to improve programming and support all child(ren)s needs. / El Centro Comunitario Goddard Rivesride participa en ALGORHYTHM (Algoritmo) – encuesta de aprendizaje socio emocional. Los datos seran recogidos y analizados con equipos basados en la red Impacto del Desarrollo Juvenil en el Sistema Alorhythm (Sistema YD iLearning). Cada participante sera asignado un identificador exclusivo. El Sistema de Aprendizaje Alorhythm no usara nombre de participantes por ninguna razón y toda la información analizada atraves de este sistema sera presentada como el resultado del grupo. El personal de the After School Program at the Bernie Wohl Center tendra acceso a esta inofrmacion para que puedan continuar mejorando el programa y apoyar las necesidades de los participantes.


Confidentiality/ Confidencialidad: Data within this system will be kept confidential in a secure database. All data collected from your child will be kept confidential and will be used by Goddard Riverside Community Center staff to increase the quality of the program/ La informacion dentro de este sistema se mantendra confidencial en una base de datos segura. Toda la informacion se mantendra confidencial y solo sera usada por el personal de G.R.C.C. para aumentar la calidad de este programa.

Voluntarily Participation: Participation is completely voluntary. If you agree that your son/daughter can take the survey, he/she will bring this form back to their program with your signed consent. / Participación es completamente voluntaria. Si usted esta de acuerdo que su hijo/a tome parte en esta encuesta, no necesita hacer mas nada. Si usted elige que su hijo/a no participe, deben devolver este formulario al programa para informar a los evaluadores que el o ella no desea ser parte de este proceso

Consent/ Consentimiento

I have read this form and understand that my child will take part in the Alorhythm evaluation. I have also been provided a signed copy this form. / He leído este formulario y entiendo que mi niño sera parte de la evaluacion Alorhythm. Tambien se me ha dado una copia firmada de este formulario.

<i>Parent/Guardian Signature/ Firma del Padre/Guardián</i>	<i>Date/Fecha</i>
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REGISTRATION CONTRACT 2019-2020/
PROGRAMMA DEPUES DE LA ESCUELA/BWC
CONTRATO DE REGISTRO 2019-2020

Youth's Last Name/Apellido		Youth's First Name/Nombre	
PROGRAM FEES/HONORARIOS DEL PROGRAMA			
Gross Annual Income		Number of People in Household	
FEE SCALE			
	Income Range/Rango de Ingresos	Fee/Costos	
1	\$0 - \$24,999	\$425	
2	\$25,000 - \$49,999	\$815	
3	\$50,000 - \$74,999	\$1,700	
4	\$75,000 or higher	\$2,500	

Program Discounts.	
Check all that apply. Each entry is a 10% discount from total fee with a maximum of 20% discount.	
<input type="checkbox"/>	NYCHA Resident
<input type="checkbox"/>	Enrolled in After School Program 2018-2019
<input type="checkbox"/>	Enrolled in Summer Camp 2019
<input type="checkbox"/>	Enrolled in GRCC Early Childhood Program Spring/Summer 2019
<input type="checkbox"/>	Enrolling one or more siblings in BWC After School Program
<input type="checkbox"/>	Staff Discount
Financial Assistant Organizations	
<input type="checkbox"/>	ACS Household
<input type="checkbox"/>	1199
<input type="checkbox"/>	Other (Foster Care, etc.)

* A non-refundable \$50.00 registration fee is required at time of registration.

(Fee is credited towards total cost)

*Payment can be made in full, weekly, bi-weekly or monthly.


*Payments must be consistent and complete by January 31, 2020.

* Se requiere una cuota de inscripción no reembolsable de \$ 50.00 al momento de la inscripción.

(La tarifa se acredita al costo total)

*El pago se puede hacer en su totalidad, semanalmente, quincenalmente o mensualmente.

*Los pagos deben ser consistentes y completos antes del 31 de enero de 2020.

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STAR LEARNING CENTER

26 West 84th Street, Fl. 2
New York, NY 10024
Phone (212) 799-2369
Fax (212) 362-8230

Are You Interested in Tutoring for Your Child? *

Tutoring is only offered to students in grades 2-12

STUDENT INFORMATION

Child's Name: _____ Today's Date: _____

School: _____ Grade: _____

My child will attend: Bernie Wohl Center Beacon Lincoln Square

My child needs tutoring in: Reading
 Writing
 Math
 Other: _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name: _____

Home Phone: _____ Cell Phone: _____

Email: _____

* We are unable to offer tutoring to students who have an IEP

We will take these requests in the order in which we receive them.
If we have space, we will call you for an appointment to register your child.



There is a \$150 registration fee for tutoring for the school year (siblings pay half).



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STAR LEARNING CENTER

26 West 84th Street, Fl. 2
New York, NY 10024
Phone (212) 799-2369
Fax (212) 362-8230

¿Está interesado en tutoría para su hijo/a? *

La tutoría es ofrecida solamente a estudiantes en grados 2-12

INFORMACIÓN DEL ESTUDIANTE

Nombre de su hijo/a: _____ Fecha: _____

Escuela: _____ Grado: _____

Mi hijo/a asistirá: Bernie Wohl Center Beacon Lincoln Square

Mi hijo/a necesita ayuda con:

- Lectura
- Escritura
- Matemáticas
- Otra área académica: _____

INFORMACIÓN DEL PADRE/GUARDIÁN

Nombre del padre/guardián: _____

Teléfono de casa: _____ Teléfono celular: _____

Correo electrónico: _____

* No podemos ofrecer tutoría a estudiantes con un IEP

Tomaremos las solicitudes en el orden en cual las recibimos.
Si tenemos espacio, le llamaremos y haremos una cita para registrar a su hijo/a.



Hay una cuota para tutoría: \$150 por el año escolar, hermanos pagan \$75.



See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME Goddard Riverside Community Center

Print the name of the child(ren) enrolled in this child care center

1. _____ 2. _____ 3. _____

DIRECTIONS

Complete SECTION A if anyone in your household

1. Participates in the Supplemental Nutrition Assistance Program (SNAP)
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR) OR
4. Is a foster child

SECTION A

SNAP Case # _____

TANF # _____

FDPIR # _____

Names of Foster Children _____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true. I understand that the center will get Federal funds based on the information I give.

Signature _____

Date _____

Complete SECTION B if no one in your household participates in SNAP, receives TANF, participates in FDPIR or if none of the children enrolled in the child care center is a foster child.

SECTION B

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 **last month** in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, child support, foster child's personal income and any other sources of income.

HOUSEHOLD MEMBER NAME	MONTHLY GROSS SALARY
1. _____	\$ _____
2. _____	\$ _____
3. _____	\$ _____
4. _____	\$ _____
5. _____	\$ _____
6. _____	\$ _____
7. _____	\$ _____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true and that all income is reported. I understand that the center will get Federal funds based on the information I give.

Signature _____

Print Name _____

LAST FOUR (4) DIGITS OF SOCIAL SECURITY NUMBER

DATE _____

FOR SPONSOR USE ONLY	
CACFP Agreement #	<u>3472</u>
Total Number of Household Members	_____
<small>(INCLUDING FOSTER CHILDREN, IF APPLICABLE)</small>	
Total Household Income \$	_____
Free	Reduced
_____	_____
Paid	_____
Date of Determination	_____
Signature of Center Staff	_____

USDA is an equal opportunity provider and employer.

CHILD & ADOLESCENT HEALTH EXAMINATION FORM
 NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS)

TO BE COMPLETED BY THE 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 _____ Work _____

Health insurance (including Medicaid)? Yes No Parent/Guardian Last Name _____ First Name _____ Email _____ Cell _____
 Parent/Guardian Foster Parent

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history (age 0-6 yrs)
 Uncomplicated Premature: _____ weeks gestation
 Complicated by _____

Allergies None Epi pen prescribed
 Drugs (list) _____
 Foods (list) _____
 Other (list) _____

Attach MAF if in-school medications needed

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

Asthma (check severity and attach MAF): Intermittent Mild Persistent Moderate Persistent Severe Persistent
 If persistent, check all current medication(s): Quick Relief Medication Inhaled Corticosteroid Oral Steroid Other Controller None
 Asthma Control Status Well-controlled Poorly Controlled or Not Controlled

Anaphylaxis Seizure disorder
 Behavioral/mental health disorder Speech, hearing, or visual impairment
 Congenital or acquired heart disorder Tuberculosis (latent infection or disease)
 Developmental/learning problem Hospitalization
 Diabetes (attach MAF) Surgery
 Orthopedic injury/disability Other (specify) _____
 Explain all checked items above. Addendum attached.

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

PHYSICAL EXAM Date of Exam: ____/____/____

Height _____ cm (____ %ile)
 Weight _____ kg (____ %ile)
 BMI _____ kg/m² (____ %ile)
 Head Circumference (age ≤ 2 yrs) _____ cm (____ %ile)

Blood Pressure (age ≥ 3 yrs) _____ / _____

General Appearance: Physical Exam WNL

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

Describe abnormalities: _____

DEVELOPMENTAL (age 0-6 yrs)
 Validated Screening Tool Used? _____ Date Screened ____/____/____
 Yes No
 Screening Results: WNL
 Delay or Concern Suspected/Confirmed (specify area(s) below):
 Cognitive/Problem Solving Adaptive/Self-Help
 Communication/Language Gross Motor/Fine Motor
 Social-Emotional or Personal-Social Other Area of Concern: _____

Describe Suspected Delay or Concern: _____

Child Care Only
 Hemoglobin or Hematocrit _____ g/dL _____ %

Child Receives EI/CPSE/CSE services Yes No

Nutrition
 < 1 year Breastfed Formula Both
 ≥ 1 year Well-balanced Needs guidance Counseled Referred
 Dietary Restrictions None Yes (list below)

SCREENING TESTS

Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk)
 Date Done ____/____/____ Results _____ µg/dL

Lead Risk Assessment (annually, age 6 mo-6 yrs)
 At risk (do BLL) Not at risk

Hearing Date Done ____/____/____ Results _____
 < 4 years: gross hearing _____ NI Abnl Referred
 OAE _____ NI Abnl Referred
 ≥ 4 yrs: pure tone audiometry _____ NI Abnl Referred

Vision Date Done ____/____/____ Results _____
 < 3 years: Vision appears: _____ NI Abnl
 Acuity (required for new entrants and children age 3-7 years)
 Right _____/_____
 Left _____/_____
 Unable to test

Screened with Glasses? Yes No
 Strabismus? Yes No

Dental
 Visible Tooth Decay Yes No
 Urgent need for dental referral (pain, swelling, infection) Yes No
 Dental Visit within the past 12 months Yes No

CIR Number _____ Physician Confirmed History of Varicella Infection Report only positive immunity:

IMMUNIZATIONS - DATES		IgG Titers	
DTP/DTap/D1	____/____/____	Hepatitis B	____/____/____
Td	____/____/____	Measles	____/____/____
Polio	____/____/____	Mumps	____/____/____
Hep B	____/____/____	Rubella	____/____/____
Hib	____/____/____	Varicella	____/____/____
PCV	____/____/____	Polio 1	____/____/____
Influenza	____/____/____	Polio 2	____/____/____
HPV	____/____/____	Polio 3	____/____/____

ASSESSMENT Well Child (Z00.129) Diagnoses/Problems (ast) _____ ICD-10 Code _____

RECOMMENDATIONS Full physical activity
 Restrictions (specify) _____
 Follow-up Needed No Yes, for _____ Appt. date: ____/____/____
 Referral(s): None Early Intervention IEP Dental Vision
 Other _____

Health Care Practitioner Signature _____ Date Form Completed ____/____/____
 Health Care Practitioner Name and Degree (print) _____ Practitioner License No. and State _____
 Facility Name _____ National Provider Identifier (NPI) _____
 Address _____ City _____ State _____ Zip _____
 Telephone _____ Fax _____ Email _____

DOHMH ONLY PRACTITIONER I.D. _____
 TYPE OF EXAM: NAE Current NAE Prior Year(s)
 Comments: _____
 Date Reviewed: ____/____/____ I.D. NUMBER _____
 REVIEWER: _____
 FORM ID# _____