NYC Early Learning Company, Inc.

Head Start

Department of Education

Beanstalk Academy

ENROLLMENT APPLICATION

Beanstalk Academy

ENROLLMENT APPLICATION CHECKLIST

NYC Early Learning Company, Inc.

Head Start

Department of Education

GENERAL

- [ ] **Application Forms** (pages 1-8)
- [ ] **Medical form & Immunizations records**
- [ ] **Proof of Age** (birth certificate, passport, or other official document of age)
- [ ] **CACFP (Enrollment form, Eligibility Form and Infant feeding form** (when applicable)**)**
- [ ] **IEP / IFSP** (when applicable)

HS/EHS

- [ ] **Proof of Income** (4 paystubs, public assistance letter, W2 or tax returns)
- [ ] **Foster care or homeless documentation** (when applicable)

DOE/UPK

- [ ] **2 Proofs of Address** (you may provide an electric or water bill, your lease agreement or mortgage statement, a federal or state letter addressed to parent) and your NYS ID
- [ ] **Offer Letter** (you can print this from your MySchools account)
- [ ] **Proof of Income** (only for extended day & year program) (4 paystubs, public assistance letter, W2 or tax returns)
- [ ] **Foster care or homeless documentation** (when applicable)

IF YOUR CHILD HAS

- [ ] **Asthma** – Asthma Action Plan
- [ ] **Allergies** – Allergy Plan
- [ ] Medication for allergies or asthma please have your doctor complete the **Medication Administration Form.**

Beanstalk Academy
ENROLLMENT APPLICATION

NYC Early Learning Company, Inc.
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Please do not leave anything blank.
If something does not apply to you, please write "N/A"

Today's Date: _____

Child's Information

_____ **DOB:** _____
(Last name, First name, Middle Initial)

Street Address: _____ **Apt #:** _____

City: _____ **State:** _____ **ZIP:** _____

Gender: ☐ M ☐ F **Hispanic or Latino:** ☐ Yes ☐ No

HRA/ACS Case Number: _____

Language: _____

Secondary Language: _____

Language Proficiency: ☐ Little ☐ Moderate ☐ None ☐ Proficient

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Bi-Racial/Multi-Racial
☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other (Explain) _____

Birth Certificate: ☐ Submitted ☐ Don't have ☐ Lost

Current Living Situation: ☐ Foster ☐ Homeless

Parent/Guardian #1

_____ **DOB:** _____
(Last name, First name, Middle Initial)

Relationship to child: ☐ Parent ☐ Grandparent ☐ Relative (other than grandparent) ☐ Foster ☐ Other: _____

Family: ☐ Single Parent Household ☐ 2 Parent Household

Email: _____ **Phone #:** _____ f / _____ / _____

Parent Education (highest grade):
☐ An advanced degree or baccalaureate degree
☐ An associate degree, vocational school, or some college
☐ A high school graduate or GED
☐ Less than high school graduate

Employment:
☐ Employed
☐ Unemployed
☐ Training
☐ School

Military:
☐ Veteran
☐ Active duty

Number of family members living in the household being supported through the family income: _____

Public Assistance status: ☐ TANF ☐ SSI ☐ WIC ☐ SNAP

Parent/Guardian #2

_____ **DOB:** _____
(Last name, First name, Middle Initial)

Relationship to child: ☐ Parent ☐ Grandparent ☐ Relative (other than grandparent) ☐ Foster ☐ Other: _____

Street Address: _____ **Apt #:** _____

City: _____ **State:** _____ **ZIP:** _____

Email: _____ **Phone #:** _____ f / _____ / _____

Parent Education (highest grade):
☐ An advanced degree or baccalaureate degree
☐ An associate degree, vocational school, or some college
☐ A high school graduate or GED
☐ Less than high school graduate

Employment:
☐ Employed
☐ Unemployed
☐ Training
☐ School

Military:
☐ Veteran
☐ Active duty

Beanstalk Academy
ENROLLMENT APPLICATION

NYC Early Learning Company, Inc.
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NYC Department of Education

Child: _____ _____
(Last name) *(First name)* *(DOB)*

Child's Health Information

☐ Private Insurance ☐ No Insurance ☐ Medicaid ☐ CHIP **Policy #:** _____

Primary Care Physician: _____ Phone #: _____

Address: _____

Dentist: _____ Phone #: _____

Address: _____

Nutrition Information: ☐ Full Diet / No Restrictions ☐ Nutritional Concern / Special Diet: _____

Does your child have any allergies? ☐ Yes ☐ No

Does your child have any chronic conditions? ☐ Yes ☐ No

If yes:

☐ ACD ☐ ADHD ☐ Asthma ☐ Seizures ☐ Allergies ☐ Hearing ☐ Vision ☐ Diabetes

☐ BLL >5 ☐ Other: _____

Related Services

Do you have any concerns regarding your child's development? ☐ Yes ☐ No

If yes, please explain: _____

Has your child been evaluated due to your concern or ever received services? ☐ Yes ☐ No

Does your child have an IEP or IFSP? ☐ Yes ☐ No

If yes: **What services are they receiving?** ☐ OT ☐ PT ☐ SPEECH ☐ ABA ☐ COUNSELING

☐ SEIT ☐ Other: _____

_____ I certify that the information provided is correct to the best of my knowledge and is subject to verification.

Parent / Guardian Signature: _____ **Date:** _____

Beanstalk Academy
CONSENT FORM

NYC Early Learning Company, Inc.
Head Start

NYC Department of Education

Emergency Contact and Authorized Escort List

To maintain the safety of your children, parents/guardians must complete, sign, and return this form to Beanstalk Academy upon enrollment. This form shall be updated annually or when there is any change in authorized escort information.

Emergency Contacts: *Only individuals listed (and checked off) below will be considered as designated emergency contacts. Parents and guardians do not have to be listed below. An emergency contact is someone who Beanstalk Child Care Academy has permission to contact in the event that a parent/guardian cannot be reached during an emergency, for the purpose of communicating critical information.*

Authorized Escort(s): *Only individuals listed (and checked off) below will be considered as an authorized escort(s) and will be allowed to pick-up your child. Parents and guardians do not have to be listed below. Government issued ID will be required at time of pick-up. All authorized escorts must be above 16 years of age.*

The New York City Health Code requires Child Care Centers to obtain and maintain for every child a list of all persons authorized by parents/guardians to escort the child from Child Care. No child may leave the Center with any individual whose name is not on file at the Center as an authorized escort.

Name: ______ **Relationship to Child:** ______ **Phone #:** ______ **Home Address:** ______ ☐ Emergency Contact ☐ Authorized Escort	**Name:** ______ **Relationship to Child:** ______ **Phone #:** ______ **Home Address:** ______ ☐ Emergency Contact ☐ Authorized Escort
Name: ______ **Relationship to Child:** ______ **Phone #:** ______ **Home Address:** ______ ☐ Emergency Contact ☐ Authorized Escort	**Name:** ______ **Relationship to Child:** ______ **Phone #:** ______ **Home Address:** ______ ☐ Emergency Contact ☐ Authorized Escort
Name: ______ **Relationship to Child:** ______ **Phone #:** ______ **Home Address:** ______ ☐ Emergency Contact ☐ Authorized Escort	**Name:** ______ **Relationship to Child:** ______ **Phone #:** ______ **Home Address:** ______ ☐ Emergency Contact ☐ Authorized Escort

I ______________________ authorize Beanstalk Academy to contact in case of
(parent/guardian last name, first name, middle initial)

emergency or to release my child ______________________ to the individuals
(child last name, first name, middle initial)

I have identified above.

Parent / Guardian Signature: ______________ **Date:** ______

NYC Early Learning Company, Inc.
Head Start

Department of Education

General Consents

Child: _____ _____
(Last name) *(First name)* *(DOB)*

Parent/Guardian: _____
(Last name) *(First name)*

Neighborhood Walking Trip Consent *(please initial)*

_____ I give permission for my child to participate in neighborhood walking trips including walks to local parks and playgrounds. Field trips require a separate consent form and will be sent home prior to any field trip.

Photo Consent *(please initial)*

_____ I hereby give Beanstalk Academy and its subsidiaries (hereafter referred to as Beanstalk Academy and those acting with Beanstalk Academy) permission and authority to use, publish and/or republish photographic pictures of myself and/or my minor child.

The photographic pictures may be altered in character or form on reproductions in color and/or black and white through any media used by Beanstalk Academy for any Beanstalk Academy purpose including, without limitation, use in any printed materials, on Beanstalk Academy's website on the internet and related websites, and in social media.

I release and discharge Beanstalk Academy and its representatives, employees, or any person(s) and/or corporation(s) for whom Beanstalk Academy may be acting, including any firm publishing and/or distributing the finished product, in whole or in part, from any liability resulting from the distortion, bluffing, alteration, or optical illusion, either unintentionally or otherwise, that occurs or is produced in the taking, processing, or reproduction of the finished product, its publication and/or distribution.

By signing below, I also acknowledge that:
I understand and agree to all consents and screenings listed on this form. The authorization remains effective throughout my child's enrollment, but I may also choose to revoke it at any time by notifying Beanstalk Academy in writing. I am over 18 years of age and competent to contract in my own name. I have the authority to execute this document on behalf of my minor child.

Parent / Guardian Signature: _____ **Date:** _____

NYC Early Learning Company, Inc.
Head Start

Department of Education

Medical Consents

Child: _____ _____
(Last name) *(First name)* *(DOB)*

Parent/Guardian: _____
(Last name) *(First name)*

OTC Medications *(please initial)*

_____ I give permission for the administration of the following non-ingestible over the counter medications, including sunscreen, diaper creams, and insect repellent, as needed. I understand that such OTC medication will be brought to school in its original container and will be clearly labeled with my child's name.

Consent for Epinephrine Administration (EpiPen) *(please initial)*

_____ In the event that my child experiences a severe allergic reaction while under the supervision of Beanstalk Academy, I hereby grant the school permission to administer an initial dose of Epinephrine and then immediately call 911. I understand that, should emergency services direct the school to do so, a 2nd dose of Epinephrine may be administered to ensure the child's imminent safety.

Emergency Treatment Authorization

I _____ hereby state that I am the legal guardian(s) of _____

DOB _____, who resides with me at _____. I authorize that for emergency purposes, a school designated employee may provide consent for my child to receive medical attention (e.g. necessary examination, medical diagnosis, surgery, treatment, and/ or EMS/hospital care). In the event that my child needs to be transported, a Beanstalk Academy staff member will accompany my child at all times. I understand that every effort will be made to contact the Emergency Contact persons provided in the Emergency Release Contact Form.

By signing below, I also acknowledge that:
I understand and agree to all consents and screenings listed on this form. The authorization remains effective throughout my child's enrollment, but I may also choose to revoke it at any time by notifying Beanstalk Academy in writing. I am over 18 years of age and competent to contract in my own name. I have the authority to execute this document on behalf of my minor child.

Parent / Guardian Signature: _____ **Date:** _____

NYC Early Learning Company, Inc.
Head Start

Department of Education

Child Screenings

Child: _____ _____
(Last name) *(First name)* *(DOB)*

Parent/Guardian: _____
(Last name) *(First name)*

To ensure the health and development of your children, Beanstalk Academy will be conducting various screenings, which will be performed either by in-house staff or fully certified external resources hired or contracted by Beanstalk Academy. All screenings will be done on the premises, with results and feedback communicated to the family in a timely manner. The following is a list of screenings that Beanstalk Academy may conduct:

Please initial:

_____ **Hearing**
An age-appropriate hearing screening will be performed within 45 days of enrollment and annually.

_____ **Vision**
An age-appropriate vision screening will be performed within 45 days of enrollment and annually thereafter.

_____ **Blood Pressure**
Children aged 3 and older will have their blood pressure checked annually.

_____ **HGB**
Hemoglobin blood levels will be checked annually.

_____ **Dental Screening**
Dental Screenings will be provided to children within 90 days of enrollment and annually thereafter.

_____ **Social Emotional**
Parents and center-based staff will collaborate to complete a behavioral questionnaire for each child within 45 days of enrollment and annually thereafter.

_____ **Development and ED**
Education staff will conduct a developmental screening within 45 days of enrollment and annually thereafter.

_____ **Growth Assessment**
Child's height and weight will be measured and recorded every six months.

_____ **Nutrition Assessment**
With information provided by families, a nutritionist will conduct a dietary/growth assessment within 90 days of enrollment and annually thereafter.

_____ **Mental Health**
Mental Health professionals will conduct classroom observations and provide referals or classroom support as applicable.

_____ I give permission for Beanstalk Academy to conduct all health and developmental screenings as listed above or as deemed necessary. Screenings may be done by either Beanstalk Academy staff/consultants or by certified organizations who partner with Beanstalk Academy for the health and well-being of my child.

By signing below, I also acknowledge that:
I understand and agree to all consents and screenings listed on this form. The authorization remains effective throughout my child's enrollment, but I may also choose to revoke it at any time by notifying Beanstalk Academy in writing. I am over 18 years of age and competent to contract in my own name. I have the authority to execute this document on behalf of my minor child.

Parent / Guardian Signature: _____ **Date:** _____

NYC Early Learning Company, Inc.
Head Start

Department of Education

Consent to Obtain and Release Child Information

Child: _____ _____
(Last name) *(First name)* *(DOB)*

Parent/Guardian Name(s): _____

Please initial:

_____ I authorize Beanstalk Academy to share Information with early intervention / Local educational agencies from my child's records for purposes pertaining to his/her overall development. I understand these conversations will be confidential and respectful with the goal of helping my child grow and learn which will increase their overall success in the program.

_____ I hereby authorize any early intervention / local educational agencies / Medical agencies to release and obtain information and/or copies of files pertaining to my child (including medical forms, IFSP or IEP, evaluation, session notes) to Beanstalk Academy. I also understand this information may be shared with other partner agencies working with my child for the purposes of providing services, screenings and/or evaluations.

- **IEP**
  Individualized Education Plan; document from NYSED that outlines mandated special education and/or related services.
- **IFSP**
  Individualized Family Services Plan; document from NYSDOH's Early Intervention Program that outlines mandated special education and or related services.
- **Nutrition**
  Nutrition Screenings assess a child's dietary and growth patterns as well as best recommendations.
- **Anecdotals Child Development**
  Teacher notes that reflect on a child's progress and behavior within the classroom setting.
- **Mental Health**
  Mental Health Screenings, General Observations, Referrals, or Recommended Behavior Intervention Plans
- **Medical Records**
  Annual physicals, well-check documentation, immunization records, etc.

By signing below, I also acknowledge that:
I understand and agree to all consents and screenings listed on this form. The authorization remains effective throughout my child's enrollment, but I may also choose to revoke it at any time by notifying Beanstalk Academy in writing. I am over 18 years of age and competent to contract in my own name. I have the authority to execute this document on behalf of my minor child.

Parent / Guardian Signature: _____ Date: _____

Beanstalk Academy
PAYMENT AGREEMENT

NYC Early Learning Company, Inc.
Head Start

NYC Department of Education

I. Parent-Provider Payment Agreement

The following agreement is between _____ **and**
Parent(s) of Enrolled Child

Beanstalk Academy (NYC Early Learning Company, Inc.) located at _____ **for**
Center-Based Location

enrollment of: _____ - ____ / ____ / ____
(Child's name) *(Date of Birth)*

This agreement is effective as of ____ / ____ / ____
(Date)

II. Standard Rates and Payment Policies

Please select childcare schedule needed (check one):

Option 1: ☐ **Full-Day** (covers entire hours of program operation)

Option 2: ☐ **Extended Hours** (covers only early drop off and late pick-up for HS/EHS & DOE program only)

The fee will be $ _____ **per week / per month** (circle one)

Payment is to be given to Center Director (check one):

☐ **Weekly** (Friday for following week)

☐ **Bi-weekly** (every other Friday)

☐ **Monthly** (1st of the month)

*Payment can be made by Cash, Check, Credit Card, or Money Order (there will be a fee of $35 incurred for any returned check).

III. Policies for Absences, School Closures, and Late Pick-Up

- All closures for holidays and staff development are listed on Beanstalk's calendar and factored into rates.
- Payment arrangements are due in full and as scheduled, regardless of student absences or vacations. Whether a child is sick or at home, all scheduled payments still apply.
- In the event that the provider is unable to provide care due to an emergency (e.g., facility hazard or snow closure), Beanstalk Academy will offer a prorated refund only if/when closures exceed 3 consecutive days.
- A parent/guardian will not be able to drop off or pick up a child outside of program operating hours. The following overtime rate will be charged, as needed, for late pick-up: **$1.00** per **Minute.**

IV. Termination Procedure

This agreement begins on ____ / ____ / ____ and may be terminated by either parent/guardian or provider by giving 2 weeks' written notice. The provider may terminate the contract without notice if the parent/guardian is over 2 weeks' late with scheduled payments. Parent/guardian may terminate the contract without notice if the provider does not comply with NYS childcare regulations. Changes to the contract, desired by either party, must be made and acknowledged in writing by both parties at least 2 weeks before the desired change takes effect. A new contract should be signed at that time to reflect the changes.

V. Signatures

By signing this agreement, all parties agree to all of the above terms and policies, including financial responsibility for childcare provided. The provider is responsible for providing all parties a copy of the signed agreement.

_____	_____	____ / ____ / ____
Provider's Name	*Provider's Signature*	*Date*
_____	_____	____ / ____ / ____
Parent / Guardian Name	*Parent / Guardian Signature*	*Date*

Beanstalk Academy

CACFP ENROLLMENT FORM

NYC Early Learning Company, Inc.

Head Start

Department of Education

My Child, _____ DOB: ____ /____ /____ is enrolled at NYC Early Learning Company (Beanstalk Academy). His/her start date is ____ /____ /____ .

My child will attend: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Hours of Care: 7:30 am – 6:00 pm

Receiving Meals: ☐ Breakfast ☐ Lunch ☐ PM Snack

Parent / Guardian Signature: _____ Date: _____

Child Withdrawn on: ____ /____ /____

NEW YORK STATE DEPARTMENT OF HEALTH
Child and Adult Care Food Program

Income Eligibility Form
for Child Care Centers

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME NYC EARLY LEARNING COMPANY INC - BEANSTALK CHILDCARE ACADEMY

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 _____

FOR SPONSOR USE ONLY

CACFP Agreement # 6806

Total Number of Household Members _____
(INCLUDING FOSTER CHILDREN, IF APPLICABLE)

Total Household Income $_____

Free _____ Reduced _____ Paid _____

Date of Determination _____

Signature of Center Staff _____

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 _____

USDA is an equal opportunity provider and employer.

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this form. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the form. The Social Security Number is not required when you: apply on behalf of a foster child; provide a SNAP, TANF or FDPIR number; or when you indicate that the adult household member signing the form does not have a Social Security Number. We will use your information to determine if the center is eligible for free or reduced-price meal reimbursement and for administration and enforcement of the Program.

INSTRUCTIONS FOR COMPLETING DOH-3688

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) unemployment compensation; (7) government civilian employee or military retirement, or pensions or veteran's payments; (8) private pensions or annuities; (9) alimony or child support payments; (10) regular contributions from persons not living in the household; (11) net royalties; (12) military benefits received in cash, such as housing allowance except if you are in the Military Housing Privatization Initiative; and (13) 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.

INSTRUCTIONS FOR PARENTS OR GUARDIANS

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

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

Section A: If anyone in your household participates in the Supplemental Nutrition Assistance Program (SNAP), receives Temporary Assistance for Needy Families (TANF) or participates in the Food Distribution Program on Indian Reservations (FDPIR), complete Section A only. Write down the SNAP, TANF or FDPIR number (do not use your ACS or DSS child care subsidy number). Then 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 child care, write in the names of the foster children.

Section B: Complete this section if you did not complete Section A. Write in your name and the names of all other adults and children living in the household, including unrelated people, even if they do not have any income. Do not include the children in child 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, above. If any amount last month was more or less than the usual, write in that person's usual income.

The last four digits of the Social Security Number of the adult signing the certification is required. If you do not have a Social Security Number, write *none*. The form must be signed by an adult member of the household.

INSTRUCTIONS FOR CENTERS AND SPONSORS

The *For Sponsor Use Only* section is to be completed, signed and dated by center or sponsor staff. The sponsor/center representative must review the income eligibility form and ensure that it is completed as indicated in the instructions above. Then indicate the following:

The CACFP Agreement Number.

Total Number of 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 child care and the number of foster children, if applicable.

Total Household 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 form must be categorized as *paid.*

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

Incomplete forms (missing signatures, income information, last four digits of Social Security Number or SNAP, TANF or FDPIR numbers) are categorized in the paid category.

The income eligibility form is valid until the last day of the month one calendar year from the date it is signed by the household member. For example, a form signed on May 12, 2014 is valid until May 31, 2015.

CACFP Agreement # 6806

NEW YORK STATE | Department of Health | Child and Adult Care Food Program

INFANT FEEDING STATEMENT

Baby's Name_____ Date of Birth _____

Dear Parent/Guardian:

This center participates in the Child and Adult Care Food Program and we will give your baby Enfamil Gentlease/Infant and solid food. If you want to bring breast milk or your own

NAME OF FORMULA

formula or food, you can do that instead. Also, we encourage moms to come to the center to nurse their babies.

Please indicate your choice below.

BREAST MILK/FORMULA (CHECK ONE)	FOOD (CHECK ONE)
_____The center can give my baby the formula they buy. _____I will bring breast milk or formula for my baby.	_____The center can give my baby solid foods when I tell them the baby is ready. _____I will bring solid foods for my baby.

Parent's Signature _____ Date _____

This institution is an equal opportunity provider.

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** | **District** __ __ **Number** __ __ __ | **Phone Numbers** Home _____ Cell _____ Work _____

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

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
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes ***(attach MAF)***
☐ Orthopedic injury/disability
Explain all checked items above.

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) _____
☐ ***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

Nl Abnl	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*	*Nl 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? ☐ Yes ☐ No — Date Screened ___/___/___

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 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	*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
—— Child Care Only ——		
Hemoglobin or Hematocrit	____/____/____	_____ g/dL _____ %

Hearing

	Date Done	*Results*
< 4 years: gross hearing	____/____/____	☐*Nl* ☐*Abnl* ☐*Referred*
OAE	____/____/____	☐*Nl* ☐*Abnl* ☐*Referred*
≥ 4 yrs: pure tone audiometry	____/____/____	☐*Nl* ☐*Abnl* ☐*Referred*

Vision

	Date Done	*Results*
<3 years: Vision appears:	____/____/____	☐ *Nl* ☐ *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 ☐

IMMUNIZATIONS – DATES

Report only positive immunity:

															IgG Titers	Date
DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___			Tdap	___/___/___	___/___/___			Hepatitis B	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___			MMR	___/___/___	___/___/___			Measles	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___			Varicella	___/___/___	___/___/___			Mumps	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___			Mening ACWY	___/___/___	___/___/___			Rubella	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___			Hep A	___/___/___	___/___/___			Varicella	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___			Rotavirus	___/___/___	___/___/___			Polio 1	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___			Mening B	___/___/___	___/___/___			Polio 2	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___			Other _____	___/___/___	_____ ___/___/___			Polio 3	___/___/___

ASSESSMENT ☐ **Well Child** (Z00.129) ☐ **Diagnoses/Problems** *(list)* **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# ☐☐☐☐☐☐☐☐☐☐

NYC Early Learning Company, Inc.
Head Start

Department of Education

2022-2023

SCHOOL YEAR RATES

Age Group	Monthly	Weekly	3 Days (Weekly)	Extended Hours	EI
0 - 18 months	$ 1,870	$ 450	$ 290	$ 180	$ 385
18 - 36 months	$ 1,450	$ 350	$ 230	$ 140	$ 300
36 - 60 months	$ 1,330	$ 320	$ 210	$ 130	N/A
SACC After School PT	$ 740	$ 175	$ 115	N/A	N/A
SACC Summer FT	$ 1,130	$ 260	$ 175	N/A	N/A

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