March 2018

Office Use Only	
Date Application Received:	
Enrollment Start Date:	
Intake Specialist/Staff:	
Additional Information:	

NYC Department of Youth & Community Development | COMPASS NYC THE COMPREHENSIVE AFTERSCHOOL SYSTEM OF NEW YORK CITY | SONYC | Beacon CENTERS OF NEW YORK CITY | CORNERSTONE

DYCD Universal Participant Intake: *Youth & Adult Application*

Welcome to the Department of Youth and Community Development (DYCD)! DYCD is a New York City agency that funds programs for youth and families. These programs are operated by Community Based Organizations (CBOs).This form will allow you or your child to apply to a DYCD Comprehensive Afterschool System (COMPASS), Beacon, or Cornerstone youth or adult program. Please complete this form fully and return to the CBO that operates the program. One application will be accepted per person per site. **Submission of an application does not guarantee enrollment in the program.** Further paperwork and information may be required to determine program eligibility. If accepted, program will be **at no cost** to the participant. The following application items are collected for informational and program planning purposes only: *Income, Gender, Race, Ethnicity, Language, Population Type, Household Information and Health Insurance Status.* Responses to these questions will not impact your eligibility to receive services and will not be shared outside of DYCD without the applicant's permission.

Part I: Applicant Information

For the purposes of this application, *applicant* refers to the person applying to receive services. Select one:

☐ I am completing this application for myself
☐ I am a parent or guardian completing this application for my child
☐ I am a relative/non-relative, completing this application on behalf of the applicant

Applicant's First Name:	**Applicant's Last Name:**	**MI:**

Applicant's Date of Birth (MM/DD/YEAR):

Applicant's Gender (Select One):	**Applicant's Race** (Select all that Apply):	**Applicant's Ethnicity** (Select One):
☐ Male ☐ Female ☐ Gender Nonconforming	☐ American Indian and Alaskan Native ☐ Asian ☐ Black or African- American ☐ Native Hawaiian and Other Pacific Islander ☐ White or Caucasian ☐ Other	☐ Hispanic or Latino(a) ☐ Not Hispanic or Latino(a)

Applicant's Primary Address (*Number and Street*):	**Apt. Number:**
City:	**Zip Code:**

☐ **Applicant lives in a NYCHA Development (please provide name)** _____

Part II: Contact Information

Applicant's Contact Information

For youth without contact information, skip to the next section to provide parent/guardian contact information

Write down phone numbers for the applicant and circle the preferred method of contact:

☐ Home _____ ☐ Cell _____

☐ Work _____ ☐ Email _____ ☐ No Email

Parent/Guardian Information

This section is required for Applicants under 18

Parent/Guardian Name: _____

Write down all phone numbers and circle the best number to call in case of an emergency:

☐ Home _____ ☐ Cell _____

☐ Work _____ ☐ Email _____ ☐ No Email

Address: ☐ Same as Participant	City:	State:	Zip Code:

Emergency Contact Information

At least one emergency contact must be identified

1

Emergency Contact #1 Name:	Relationship to Participant: ☐ Emergency contact is parent/guardian of participant

Write down all phone numbers and circle the best number to call in case of an emergency:

☐ Home _____ ☐ Cell _____

☐ Work _____ ☐ Email _____ ☐ No Email

Address: ☐ Same as Participant	City:	State:	Zip Code:

2

Emergency Contact #2 Name:	Relationship to Participant: ☐ Emergency contact is parent/guardian of participant

Write down all phone numbers and circle the best number to call in case of an emergency:

☐ Home _____ ☐ Cell _____

☐ Work _____ ☐ Email _____ ☐ No Email

Address: ☐ Same as Participant	City:	State:	Zip Code:

This section is for parents/guardians enrolling their children		
Emergency contacts listed in Section II are authorized to pick up the child unless otherwise noted. **The following additional people are authorized to pick up my child:**		
Name:	**Phone #:**	**Relationship:**
Name:	**Phone #:**	**Relationship:**
Name:	**Phone #:**	**Relationship:**
The following people MAY NOT pick up my child:		
Name:	**Name:**	**Name:**

Part III: Applicant's Education/Work Status

Applicant's Education Status (Select One):

☐ Full-Time Student*** ☐ Part-Time Student*** ☐ Not in School****

***If applicant is a *Part-Time Student* or *Full-Time Student*: **Select applicant's current grade** (Select One):
****If applicant is *Not in School:* **Select the last grade completed by the applicant** (Select One):

Elementary School:	☐ Pre-K ☐ K ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th
Middle School:	☐ 6th ☐ 7th ☐ 8th
High School:	☐ 9th ☐ 10th ☐ 11th ☐ 12th
Community College:	☐ 1st year ☐ 2nd Year ☐ 3rd year ☐4th Year ☐ 5th year ☐ 6th Year+
College/University:	☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior
Other:	☐ High School Equivalence (HSE) ☐ Vocational/Trade School ☐ Foreign Degree

Applicant's Current Work Status (Select One):

☐ Employed Full-Time	☐ Employed Part-Time	☐ Retired
☐ Unemployed (Short-Term, 6 months or less)	☐ Unemployed (Long-term, more than 6 months)	☐ Unemployed (Not in labor force)
☐ Migrant Seasonal Farm Worker	☐ Not applicable (applicant is under 14 years of age)	

Required for Full-Time Students

Student ID/ OSIS:	**School Type:** ☐ Public ☐ Charter ☐ Private ☐ Other _____
School Name:	

School Address:	**City:**	**Zip Code:**

Part IV: Health Information

Applicant's Health Information

Please answer the questions below and provide additional details in the space provided. Many needs or health challenges can be accommodated and may not limit enrollment in the program.

Does the applicant have any allergies? (food, medication, etc.)

☐ No ☐ Yes _____

Does the applicant have asthma?

☐ No ☐ Yes

Does the applicant have special health care needs?

☐ No ☐ Yes _____

Does the applicant take medication for any condition or illness?

☐ No ☐ Yes _____

Are there activities the applicant cannot participate in?

☐ No ☐ Yes _____

Please provide any additional health information details:

☐ N/A

Please list any accommodation(s) you are requesting for yourself/the applicant:

☐ N/A

Applicant's Health Insurance Status

Does the applicant have health insurance? (Select One):

☐ Yes ☐ No
☐ Decline to Answer

***If yes,* what kind of health insurance does the applicant have?** (Check all that Apply):

☐ Medicaid
☐ Medicare
☐ State Children's Health Insurance Program
☐ Employment-Based
☐ Direct-Purchase
☐ State Children's Health Insurance for Adults
☐ Military Health Care
☐ Decline to Answer

***If you do not have health insurance,* do you want to be contacted by someone else with information about signing up for public health insurance?** (Select One):

☐ Yes ☐ No ☐ Decline to Answer

***If you would like to be contacted about signing up for public health insurance,* what is your preferred method of contact?** (Select One):

☐ Email ☐ Phone ☐ US Mail ☐ Via provider
☐ Decline to Answer

Part V: Additional Applicant Information

How well does the applicant speak English? (Select One):

☐ Fluent/Very well
☐ Well
☐ Not well
☐ Not well at all

Applicant's Primary Language (Select One):

☐ English	☐ Albanian	☐ Arabic
☐ Bengali	☐ Chinese*	☐ French
☐ Fulani	☐ German	☐ Gujarati
☐ Haitian Creole	☐ Hebrew	☐ Hindi
☐ Hungarian	☐ Italian	☐ Japanese
☐ Korean	☐ Kru, Ibo, or Yoruba	☐ Mande
☐ Punjabi	☐ Persian	☐ Polish
☐ Portuguese	☐ Romanian	☐ Russian
☐ Spanish	☐ Tagalog	☐ Turkish
☐ Urdu	☐ Vietnamese	☐ Yiddish

☐ Other: _____

**including Cantonese and Mandarin*

Other Languages Spoken by Applicant (Select all that Apply):

☐ English	☐ Albanian	☐ Arabic
☐ Bengali	☐ Chinese*	☐ French
☐ Fulani	☐ German	☐ Gujarati
☐ Haitian Creole	☐ Hebrew	☐ Hindi
☐ Hungarian	☐ Italian	☐ Japanese
☐ Korean	☐ Kru, Ibo, or Yoruba	☐ Mande
☐ Punjabi	☐ Persian	☐ Polish
☐ Portuguese	☐ Romanian	☐ Russian
☐ Spanish	☐ Tagalog	☐ Turkish
☐ Urdu	☐ Vietnamese	☐ Yiddish

☐ Other: _____

☐ Not applicable (only one language spoken by applicant)

**including Cantonese and Mandarin*

Would the applicant like to receive information/ be contacted about registering to vote?** (Select One):

☐ Yes ☐ No

**Applicant is eligible to vote in U.S. federal elections if:
1) You are a U.S. citizen;
2) You meet your state's residency requirements;
3) You are 18 years old. Some states allow 17-year-olds to vote in primaries and/or register to vote if they will be 18 before the general election. Check your state's voter registration age requirements.

Is the applicant any of the following:

Parent/Legal Guardian?	☐ Yes ☐ No
Offender/Justice Involved?	☐ Yes ☐ No
Foster Care Participant?	☐ Yes ☐ No
Runaway Youth?	☐ Yes ☐ No
Veteran?	☐ Yes ☐ No
Active Military Personnel?	☐ Yes ☐ No
An Individual with a Disability?	☐ Yes ☐ No ☐ Decline to answer

***If the applicant is an individual with a disability*, please select disability type(s)** (Select all that Apply):

☐ Cognitive impairment
☐ Hearing-related
☐ Learning disability
☐ Mental or Psychiatric
☐ Physical/Chronic Health Condition
☐ Physical/Mobility Impairment
☐ Vision-related
☐ Other: _____
☐ Decline to Answer

Part VI: Household Information

For all the next set of questions, **HOUSEHOLD** is defined as any individual or group of individuals (family or non-family members) who are living together as one economic unit. **INCOME** is defined as the total annual gross income of all family and non-family members 18+years old living within the household.

The applicant lives in a household that is headed by (Select One):

- ☐ Single Parent - Female
- ☐ Single Parent - Male
- ☐ Single Person - No children
- ☐ Non-related adults with children
- ☐ Two Adults – No Children
- ☐ Two Parent Household
- ☐ Multigenerational Household
- ☐ Other: _____

Applicant's Housing Type (Select One):

- ☐ Own
- ☐ Rent
- ☐ NYCHA
- ☐ Shelter
- ☐ Homeless
- ☐ Other Permanent Housing
- ☐ Other: _____

Applicant's Household Size (Select One):

- ☐ One
- ☐ Two
- ☐ Three
- ☐ Four
- ☐ Five
- ☐ Six
- ☐ Seven
- ☐ Eight
- ☐ Nine
- ☐ Ten
- ☐ Eleven
- ☐ Twelve
- ☐ Thirteen
- ☐ Fourteen
- ☐ Fifteen
- ☐ Sixteen
- ☐ Seventeen
- ☐ Eighteen
- ☐ Nineteen
- ☐ Twenty+

Total Household Income in the last 12 Months (Select One):

- ☐ $0
- ☐ $1 to $12,060
- ☐ $12,061 to $16,240
- ☐ $16,241 to $20,420
- ☐ $20,421 to $24,600
- ☐ $24,601 to $28,780
- ☐ $28,781 to $32,960
- ☐ $32,961 to $37,140
- ☐ $37,141 to $41,320
- ☐ $41,321 to $50,000
- ☐ $50,001 to $60,000
- ☐ $60,001 to $70,000
- ☐ $70,001 to $80,000
- ☐ $80,001 to $90,000
- ☐ $90,001 to $100,000
- ☐ $100,000+
- ☐ Decline to Answer

Sources of Applicant's Household Income (Select all that Apply):

- ☐ Employment Wages
- ☐ Affordable Care Act Subsidy
- ☐ Alimony or other Spousal Support
- ☐ Child Support
- ☐ Childcare Voucher
- ☐ Earned Income Tax Credit (EITC)
- ☐ Employment Tax Credit
- ☐ General Assistance
- ☐ Housing Choice Voucher
- ☐ HUD-VASH
- ☐ LIEHEAP
- ☐ Pension
- ☐ Permanent Supportive Housing
- ☐ Private Disability Insurance
- ☐ Public Housing
- ☐ Safety Net/Home Relief
- ☐ Retirement Income from Social Security
- ☐ Social Security Disability Income (SSDI)
- ☐ Supplemental Security Income (SSI)
- ☐ Supplemental Nutrition Assistance Program (SNAP)
- ☐ Temporary Assistance for Needy Families (TANF)
- ☐ Unemployment Insurance
- ☐ VA Non-Service Connected Disability Pension
- ☐ VA Service-Connected Disability Compensation
- ☐ WIC
- ☐ Worker's Compensation
- ☐ Other: _____
- ☐ Decline to Answer

Part VII: Consents and Signatures

Pick-up/Dismissal Information

This question must be answered for parents/guardians enrolling their children

My child has permission to travel home alone at dismissal:

☐ Yes ☐ No

Consent to Participate

To the best of my knowledge the information above is true. I agree to its verification and understand that falsification may be grounds for termination of service. Information provided may be used by the City of New York to improve City services and access to those services, and to access additional funding.

If participant is 18 and over:

I acknowledge that I am 18 years of age or older and am authorized to give consent.

☐ Yes ☐ No

Participant's Signature	Participant: Print Name	Date

If participant is under 18 years old:

Parent/Guardian's Signature	Parent/Guardian: Print Name	Date

Consent for Emergency Medical Treatment

If participant is 18 and over

I am enrolled as a participant in a DYCD-funded program. In the event of a medical emergency, I hereby give consent for necessary emergency medical treatment to be obtained on my behalf. I further authorize the emergency contact(s) listed to be contacted.

☐ **Yes, I give my permission** ☐ **No, I do not give permission**

Participant's Signature	Participant: Print Name	Date

If participant is under 18 years old:

My child is enrolled as a participant in a DYCD-funded program. In the event of a medical emergency, I hereby give consent for necessary emergency medical treatment for my child to be obtained, with the understanding that I will be notified as soon as possible. I understand that every effort will be made to contact me, or, if I am unavailable, the emergency contact(s) listed, before and after medical care is provided.

☐ **Yes, I give my permission** ☐ **No, I do not give permission**

Parent/Guardian's Signature	Parent/Guardian: Print Name	Date

Consent for Photography/Videotaping and Use of Original Work

As a participant enrolled in a DYCD-funded program, please be aware that from time to time DYCD and the City of New York, its contracted providers, authorized agents, third-party organizations with which it collaborates, or other government, representatives (collectively, "Authorized Parties") may be present during program activities and special events associated with program services, both at the usual program location and at off-site events. In some cases, they may photograph, videotape, interview or otherwise record participants and their families and friends in these programs. The resulting images, videos, and interviews may be used, with or without the participant's name, in printed and electronic media such as brochures, books, print and email newsletters, DVDs and videos, websites, social media and blogs (collectively, "Media").

I hereby authorize and permit the Authorized Parties, without compensation and without further approval, to photograph and/or record my and my child's image, name, likeness, and the sound of my and my child's voice during DYCD-funded program activities and special events, and I hereby consent to the resulting images, videos and interviews being used, without compensation and without further approval by the Authorized Parties solely for non-profit, non-commercial purposes in any and all Media.

☐ Yes ☐ No

If, in the course of participating in DYCD-funded program activities and special events, any original work such as art, music, choreography, poetry, or prose (collectively, "Original Work") is created by me or my child, I hereby consent to such Original Work being used by the Authorized Parties, without compensation and without further approval, solely for non-profit, non-commercial purposes in any and all Media.

☐ Yes ☐ No

If participant is 18 and over:

I acknowledge that I am 18 years of age or older and am authorized to give consent.

☐ Yes ☐ No

Full Name of Participant	Participant's Signature	Date

If participant is under 18 years old:

Full Name of Participant	Parent/Guardian's Signature	Date

NYC Department of Youth & Community Development | COMPASS NYC | SONYC | Beacon Centers of New York City | Corner Stone

Parent/Guardian Consent to Collect and Share Student Information

The **Department of Youth and Community Development (DYCD)** provides funding for this program as part of its mission to help you assist your child reach his or her full potential. Many of our programs are run by community based organizations. We work to make sure the services you and your children receive are of the highest quality. DYCD is requesting your permission to allow us to collect information we need on your child, their participation and the quality of the services provided.

What information from your child's student records is DYCD requesting?

We are requesting your permission for the **NYC Department of Education (DOE)** to share personally identifiable information from your child's student records with DYCD. The information we would like to collect consists of biographical and enrollment information (specifically consisting of your child's name, address, date of birth, student identification number, grade, school(s) attended and transfer, discharge, and graduation data about your child); data concerning your child's school attendance (including number of days attended and absences); and academic performance data (including your child's results on state and national exams, credits earned, grades, promotion and retention status, and fitnessgram score); and data related to any disciplinary actions taken against your child (including number and type of suspensions).

We are requesting to collect the information listed above about your child on a past, present and future (i.e., ongoing) basis.

We are also requesting your permission for DYCD to share information we collect on the enrollment form from you and/or your child with DOE staff. The information includes registration information, student's interests and challenges, type of program enrolled-in and frequency of participation. This information will be used to help the school and community organization work together to meet you and your child's needs.

Who will see my child's information and how will it be safeguarded?

The only people who will see your child's individual information are DYCD and DOE staff who manage the data systems and prepare research reports and program analyses. The limited number of DYCD staff identified to receive personal information is screened, and provided extensive training to follow strict guidelines on protecting the confidentiality of information that would personally identify you or your child. Personally identifiable information collected from student records will only be shared electronically between DOE and DYCD and will be secured and protected in the DYCD data base. Personally identifiable information will not be shared with any community based organizations or their staff members. We will not use your name or your child's name in any published report. While we request your consent, your responses to the below requests will not affect your child's participation in DYCD sponsored programs.

Please check Yes or No to each of the following statements:

I understand why DYCD is asking my permission to access the information listed above from my child's student records, and I give permission to DOE to share that information with DYCD on an ongoing basis.

☐ **Yes, I give my permission** ☐ **No, I do not give my permission**

I understand why DYCD is asking my permission to share information about my child collected by DYCD with DOE staff and I give my permission to DYCD to share information with DOE on an ongoing basis.

☐ **Yes, I give my permission** ☐ **No, I do not give my permission**

Student/Applicant Name: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Additional Parent/Guardian Name *(optional)*: _____

Additional Parent/Guardian Signature *(optional)*: _____

Department of Youth & Community Development

AIR
AMERICAN INSTITUTES FOR RESEARCH

CBO: _____

School: _____

Parent Consent for Participation in Afterschool Evaluation Data Collection (SONYC and COMPASS High Participants Only)

Dear Parent:

Your child is enrolled in an afterschool program that is supported by the Department of Youth and Community Development (DYCD). American Institutes for Research (AIR) is doing a study of the afterschool programs that are part of COMPASS. In order to monitor the effectiveness of these programs and ensure their future success, DYCD, and its evaluation partner AIR, are collecting information about participants and their experiences in the afterschool program, specifically around youth leadership development. This project has been approved by the Department of Education (DOE). AIR will visit some of the afterschool programs and survey its staff as well as youth and their families to learn more about DYCD afterschool programs and how they can be improved.

We ask permission from parents to conduct the following study activities:

- Administer *10*-minute surveys to children asking about the DYCD afterschool program in which they participate and their perceptions of youth leadership development in the afterschool program
- Invite children to attend *45*-minute focus group and/or interview about the DYCD afterschool program in which they participate, focused on their experience in the afterschool program and their perceptions of youth leadership development

AIR may also collect and analyze of your child's school records from New York City Department of Education, including demographic data, school day attendance, disciplinary referrals, grade promotion, and academic performance data (e.g., test scores and grades). These data are anonymous and completely confidential. The data will be combined to the school-level and we will not be able to link this school information to individual children or their families.

Any information we collect will be used only to assess the DYCD afterschool program and will not be made public. The only people who will have access to this information are members of the AIR evaluation team. Choosing not to **participate in the evaluation will not affect your child in school, in the afterschool program, or in any other way.** We will not use your name or your child's name in any report. There are no known risks to participating in this study. Participation is voluntary and participants may withdraw at any time. Please contact Jessica Newman by phone (312-588-7341) or email (jnewman@air.org) with questions about the study.

If you have concerns or questions about your child's rights as a participant, please contact AIR's Institutional Review Board (which is responsible for the protection of project participants) at IRB@air.org, toll free at 1-800-634-0797, or c/o IRB, 1000 Thomas Jefferson St. NW, Washington, DC 20007.

TURN THE PAGE TO COMPLETE AND SIGN →

Parent Consent for Participation in Afterschool Evaluation Data Collection

Please select from the options below:

☐ *Yes, I GIVE PERMISSION FOR MY CHILD, _____, TO PARTICIPATE IN THE FOLLOWING AIR DATA COLLECTION ACTIVITIES:*

- ☐ *My child CAN complete AIR surveys about youth leadership development.*
- ☐ *My child CAN attend focus groups and interviews about their experience in the afterschool program and their perceptions of youth leadership development.*
- ☐ *Additionally, I would like to receive SMS text message updates about the evaluation of DYCD afterschool programs. AIR can send me text messages for future voluntary surveys. I understand that standard messaging may apply, and I can cancel at any time.*

☐ *No, I **DO NOT** WANT MY CHILD, _____, TO PARTICIPATE IN THE AIR DATA COLLECTION ACTIVITIES.*

_____

Signature *Date*

Consent for Audio Recording

If you gave your child permission to participate in focus groups and interviews, AIR researchers may record the student focus group and interviews for note-taking purposes. If you allow AIR to record the focus group and interviews, please sign below. No one outside of the research team will hear the recording, and the recording will be deleted when the study is concluded. Students can request to have the recorder turned off at any point.

- ☐ *Yes, I allow my child to be audio-recorded in the focus groups and interviews.*
- ☐ *No, I do not allow my child to be audio-record in the focus groups and interviews.*

_____

Signature *Date*

COMPASS PROGRAM

If you have any questions or concerns about the evaluation, please contact Jessica Newman, the project manager at AIR, at (312) 588-7341 or by email at jnewman@air.org. If you have questions about DYCD afterschool programs, visit DYCD Youth Connect http://www1.nyc.gov/site/dycd/connected/youth-connect.page or call by phone at 1-800-246-4646.

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 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

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

	WNL	Abnl		WNL	Abnl		WNL	Abnl		WNL	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	___/___/___	☐WNL ☐Abnl ☐Referred
OAE	___/___/___	☐WNL ☐Abnl ☐Referred
≥4 yrs: pure tone audiometry	___/___/___	☐WNL ☐Abnl ☐Referred

Vision

	Date Done	Results
<3 years: Vision appears:	___/___/___	☐ WNL ☐ 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

DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Tdap	___/___/___	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	MMR	___/___/___	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Varicella	___/___/___	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Mening ACWY	___/___/___	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Hep A	___/___/___	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Rotavirus	___/___/___	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Mening B	___/___/___	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Other ___	___/___/___	___/___/___

Report only positive immunity:

	IgG Titers	Date
Hepatitis B		___/___/___
Measles		___/___/___
Mumps		___/___/___
Rubella		___/___/___
Varicella		___/___/___
Polio 1		___/___/___
Polio 2		___/___/___
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# ☐☐☐☐☐☐☐☐☐☐

Hudson Guild SchoolBridge Program
ASTHMA/ALLERGY ACTION PLAN

Child has Asthma and/or Allergies: ☐Yes

Name: _____ DOB: _____

Parent/Guardian Name: _____ Address: _____

Phone (H): _____ (W): _____ (C): _____

Emergency Phone Contact Name: _____ Telephone Number: _____

Physician Child Sees for Asthma/Allergies: _____ Telephone Number: _____

DAILY ASTHMA/ALLERGY MANAGEMENT PLAN

- **Identify the things that start an asthma/allergy episode** (Check all that apply)

___Animals ___Bee/Insect Sting ___Chalk Dust ___Latex ___Change in Temperature ___Dust Mites ___Exercise ___Molds

___Pollens ___Respiratory Infections ___Smoke ___Strong Odors ___Foods such as: _____

Emergency action is necessary when the child has symptoms such as _____

_____

Steps to take during an asthma/allergy episode:

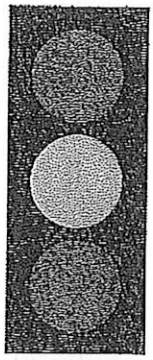
1. _____
2. _____
3. _____
4. **Allow child to stay at child care setting if:** _____

_____ _____ _____

Physician's Signature **Date** **Parent/Guardian's Signature** **Date** **Staff Member's Signature** **Date**

Asthma Action Plan

Name	Date
Doctor	Medical Record #
Doctor's Office Phone #: Day	Night/Weekend
Emergency Contact	
Doctor's Signature	



The Colors of a traffic light will help you use your asthma medicines.

Green means **Go Zone!**
Use preventive medicine.

Yellow Means **Caution Zone!**
Add quick-relief medicine.

Red means **Danger Zone!**
Get help from a doctor.

Personal Best Peak Flow _____

GO

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work and play

Peak flow from _____ to _____

CAUTION

You have *any* of these:
- First signs of a cold
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night

Peak flow from _____ to _____

DANGER

Your asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Can't talk well

Peak flow reading below _____

Use these daily preventive anti-inflammatory medicines:

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

For asthma with exercise, take:

Continue with green zone medicine and add:

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

CALL YOUR PRIMARY CARE PROVIDER.

Take these medicines and call your doctor now.

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

GET HELP FROM A DOCTOR NOW! Do not be afraid of causing a fuss. Your doctor will want to see you right away. It's important! If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT.

Make an appointment with your primary care provider within two days of an ER visit or hospitalization.

State of New York, George E. Pataki, Governor
Department of Health, Antonia C. Novello, M.D., M.P.H., Dr.P.H., Commissioner