AGES 6-10

GOOD SHEPHERD SATURDAY CAMP @ PJACC
CAMPAMENTO DE SABADO @ PJACC

Return your application to/Devuelve su applicacion a: 876 Schenck Ave Brooklyn, NY
Telephone Number/Numero de Telefono - 929.246.6400

Participant Name: _____ **Date of Birth** _____
Nombre de Participante ***Fecha de Nacimiento***

Gender: **MALE** ☐ **FEMALE** ☐ **AGE**: _____ **GRADE:** _____
Genero ***Masculino*** ***Femenino*** ***Edad*** ***Grado***

Home Address _____**Apt.**_____ **Zip code**_____
Direccion de Hogar ***Apartamento*** ***Codico Postal***

Home Phone: _____
Numero de Telefono

Cell Phone: _____
Telefono Celullar

Participant E-mail_____
Email de Paticipante

Race: ☐ African American/Black ☐ Asian American ☐ White ☐ Hispanic
Nacionalildad ☐ Other: _____

PARENT/GUARDIAN INFORMATON

Parent/Guardian #1 Name: _____ **Relationship** _____
Padre/Guarian #1 Nombre: _____ ***Relacion*** _____

Parent/Guardian # 1 Home Phone: _____ **Cell Phone**: _____
Padre/Guardian #1 Telefono de Hogar _____ ***Telefono Cellular:*** _____

Work Phone: _____ **Email Address**_____
Telefono de Trabajo _____ ***Email*** _____

Parent/Guardian #2 Name: _____ **Relationship** _____
Padre/Guardian #2 Nombre ***Relacion***

Parent/Guardian #2 Home Phone: _____**Cell Phone**: _____
Padre/Guardian #2 Telfono de Hogar ***Telefono Celular***

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Work Phone: _____ **Email Address**_____
Telefono de Trabajo: _____ ***Email*** _____

EMERGENCY CONTACT INFORMATON / *CONTACTOS DE EMERGENCIA*

Contact Name: _____ **Relationship** _____
Nombre de Contacto ***Relacion***

Home Phone: _____**Cell Phone**: _____
Telefono de Hogar ***Telefono Cellular***

Work Phone: _____ **Email Address**_____
Telefono de Trabajo ***Email Electronico***

Medical Conditions – All youth must have a valid medical attached.

Condiciones Medicos

Do you have any known Allergies/ Usted tiene Allergia? ___Yes ___No

If yes, please list items that you are allergic to/*Si tu respuesta es Si de allergia de que tienes allergia*:

_____

Do you have any medical conditions or physical disabilities? ___ Yes ___ No//*Usted tiene una*

desebilidad o una condicion medica? ____Si ____ No

If yes, what is the nature of the condition? / Si usted tiene una condicion medica, quales su condicion o disabilidad

_____

_____

Does your child carry an Epi pen? _____ Yes _____ No

¿Su hijo lleva una pluma Epi? ____ Si ____ No

If yes, an additional Epi Pen is require for our main office/ En caso afirmativo, se requiere un lápiz

Epi adicional para nuestra oficina principal.

Does your child have Asthma? ____ Yes _____ No
¿Su hijo tiene asma? ____ Si ___ No

Does your child carry an Asthma pump? _____ Yes ____ No
¿Su hijo lleva una bomba de asma? _____ Si _____ No

Consent for Emergency Medical Treatment

I give authority to the Program Agency's staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible. I understand that every effort will be made to contact me before and after medical care is provided.

Consentimiento para tratamiento médico de emergencia
Doy autoridad al personal de la Agencia del Programa para obtener el tratamiento médico de emergencia necesario para mi hijo con el entendimiento de que se notificará a la familia lo antes posible. Entiendo que se hará todo lo posible para contactarme antes y después de proporcionar atención médica.

___Yes, I give permission **___ No, I do not give permission**

Si, doy permiso ***No, no doy permiso***

Pick Up/Dismissal Information

Recogida / Despido

Children under the age of 10 must be picked up from camp by an authorized family member.
Los niños menores de 10 años deben ser recogidos del campamento por un miembro de la familia autorizado.

Is your child 10 years old? _____ Yes _____No

¿Tiene su hijo 10 años de edad? _____Si _____No

If yes, will they walk home alone after camp? ____ Yes _____ No

En caso afirmativo, ¿caminarán solos a casa después del campamento? _____Si _____No

GOOD SHEPHERD SERVICES
We see what can be.

PRINCE JOSHUA AVITTO COMMUNITY CENTER

If no, please list all persons that <u>are allowed</u> to pick up your child:

En caso negativo, enumere todas las personas que pueden recoger a su hijo:

1. **First Name/*Nombre*_____ Last Name/*Apellido* _____Phone_____**
2. **First Name/*Nombre*_____ Last Name/*Apellido* _____Phone_____**
3. **First Name/*Nombre*_____ Last Name/*Apellido* _____Phone_____**

Please list any individuals that <u>are not allowed</u> to pick up your child:

4. **First Name/*Nombre*_____ Last Name/*Apellido* _____Phone_____**
5. **First Name/*Nombre*_____ Last Name/*Apellido* _____Phone_____**
6. **First Name/*Nombre*_____ Last Name/*Apellido* _____Phone_____**

Attendance Policy

Participants that miss 3 consecutive classes without communicating with valid reason to the Good Shepherd administrative office will be removed from the class roster and will have to re-enroll for the following semester. Youth that are not authorized to walk home alone will be waiting in the main office for pick up by ONLY the authorized family members listed on this application. Authorized family members will be given a 5 minute grace period after the end of activities for pick up. Youth that are not picked up after the grace period will be released to the supervision of the NYPD 75th precinct. If authorized family members continue to be late for pick up, the participant can be discharged from activities by the discretion of the Program Director.

AGREEMENT, RELEASE FROM LIABILITY, WAIVER OF CLAIMS & ASSUMPTION OF RISK

I agree, on behalf of myself, my heirs, executors, agents, assigns, and representatives, hereby indemnify, release and forever hold harmless Good Shepherd Services a community-based organization at the Prince Joshua Avitto Community Center ("PJACC"), and its community partners as well as their directors, employees and instructors, from any and all claims of liability arising from any accident, personal injury, death, or property loss or damage sustained by my child/myself/the minor child for whom I am a legal guardian, while participating in activities connected with Good Shepherd programs at the Prince Joshua Avitto Community Center, including classes, performances, or other activities. By signing, I certify that I have notified Good Shepherd Services, Directors, and instructors of all known illnesses and medical conditions in the above medical section of this registration form. I accept full responsibility for providing adequate health and accident insurance coverage for the protection of all of the following who participate in these programs/activities: my child/myself/the minor child for whom I am a legal guardian. Further, I understand and acknowledge that there may be physical contact between directors, employees, staff, instructors and students during certain activities, trainings, workshops, performances associated with classes at PJACC. I understand that at times for proper instruction and safety, physical contact maybe required and necessary. I authorize Good Shepherds Services, through its employees, to take any appropriate steps they deem necessary to protect the safety of myself and other participants and provide medical assistance as needed in the event of an emergency.

I have carefully read this agreement, waiver, release, & assumption of risk and fully understand its contents. I understand that this is an assumption of risk and release of liability, and I sign it on my own free will. By signing, I also certify that I am at least 18 years of age, a legal adult under New York State law and the legal guardian of the youth registering for programs at the Prince Joshua Avitto Community Center.

☐ I also authorize Good Shepherd Services to take photos and record videos of my child/myself/the minor child for whom I am a legal guardian. If I am signing this in my capacity as the legal guardian of a minor child, I authorize Good Shepherd Services and its community partners to use photos and videos of myself for promotional purposes.

Youth Participant Name: _____

Parent/Guardian Name: _____

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

GOOD SHEPHERD SERVICES

We see what can be.

General Agency Media Consent, Release and Waiver

I hereby give Good Shepherd Services permission:

1. For unlimited use, both now and in the future, of any and all
   - photographs and likenesses of me or my child(ren) participating in program events and activities;
   - video that has been filmed of me or my child(ren) during program events and activities;
   - interviews that have been conducted with me or my child(ren) during program events and activities;

2. To use or publish these photographs, likenesses, videos or words for any purpose in any medium, including but not limited to brochures, publicity campaigns, the Good Shepherd Services website, in order to publicize services, recruit foster and adoptive parents) and /or seek financial support for Good Shepherd Services.
   - I understand that participation in photography, videos and interviews is entirely voluntary.
   - I understand the purpose of this document and appreciate that my picture, likeness, first name and words will be publicly disclosed.
   - I hereby release and discharge Good Shepherd Services from any cause of action, claim and liability in connection with the use of these photographs, videos and interviews. I further release Good Shepherd Services from liability, claim and/or cause of action if I voluntarily or inadvertently disclose confidential information about myself and/or my child(ren).
   - Good Shepherd Services acknowledges that it will not knowingly use or publish the photographs/videos/interviews in any way that would render them misleading.
   - I expressly consent to permit Good Shepherd Services to share photographs, likenesses, videos of me and/or my child(ren), and interviews conducted with me or my child(ren) with its business partner organizations.
   - I have read this document and fully understand its contents. I have been given an opportunity to have my questions about this document answered.
   - I am the person, or the parent or legal guardian of the person(s) named below. I have the legal authority to consent to these terms on behalf of any minor named below.
   - I hereby consent to the terms of this Consent, Release and Waiver.

Date: _____

Name of Individual(s) to Be Photographed/Filmed/Interviewed:

_____

Address: _____

City, State ZIP: _____

Telephone: _____

Date of Birth: _____

Signature of Individual/Parent/Guardian (for child(ren) under 18 years):

_____

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? 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 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 ☐

Report only positive immunity:

IMMUNIZATIONS – DATES

DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	

Tdap	___/___/___	___/___/___	
MMR	___/___/___	___/___/___	___/___/___
Varicella	___/___/___	___/___/___	___/___/___
Mening ACWY	___/___/___	___/___/___	___/___/___
Hep A	___/___/___	___/___/___	___/___/___
Rotavirus	___/___/___	___/___/___	___/___/___
Mening B	___/___/___	___/___/___	___/___/___
Other ____________	___/___/___	____________	___/___/___

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# | | | | | | | | | | |