H.E.S. 2021-2022 AFTER-SCHOOL PROGRAM

REGISTRATION BOOKLET

Included documents and online enrollment are required for program attendance*

P: 718-241-3000
E: AFTERSCHOOL@THEHES.ORG
WWW.THEHES.ORG

*Additional documents may be required dependent on program type.

H.E.S. JCC
YOUR Community Center!

The H.E.S. After School Registration Form

Parent/Guardian Information

First Name: _____ Last Name: _____
Phone: _____ Email: _____
Address: _____ Apt/Fl: _____
City: _____ State: _____ Zip Code: _____

Participant Information

First Name:_____ Last Name: _____
Gender: _____ DOB: _____ Grade in the Fall: _____

Authorized Pick-up and Emergency Contact Information

Full Name: _____ Relationship: _____
Role: Emergency Contact | Pick-up Cell Phone Number_____
Full Name: _____ Relationship: _____
Role: Emergency Contact | Pick-up Cell Phone Number_____
Full Name: _____ Relationship: _____
Role: Emergency Contact | Pick-up Cell Phone Number_____

Child Care Program (Please Circle Program) - Vacation Program Y/N __ Extended Day Y/N __
Public School ASP | Charter School ASP | SONYC | Other _____

Fee Category (Please Circle)
Private Pay | 11-99 | Voucher | Other

_____

Fee Amount _____

Payments/Discounts _____

Consent for Emergency Medical Treatment and Transportation:

☐ *I hereby give authority to the Hebrew Educational Society Year-Round After School and Staff to obtain necessary emergency medical treatment for my child/ren with the understanding that the family will be notified as soon as possible.*

☐ *I give permission for my children to use the HES bus as transportation for the After-School and Camp programs.*

Signature: _____ Date: _____

H.E.S. JCC
YOUR Community Center!

THE HEBREW EDUCATIONAL SOCIETY
9502 SEAVIEW AVENUE, BROOKLYN NY 11236
THEHES.ORG | 718.241.3000

PROUD PARTNER UJA FEDERATION

HEALTH RECORD FOR CHILDREN IN DAY CAMPS & AFTERSCHOOL & YOUTH CENTERS

(This side to be filled in by parent before presentation to physician)

NAME OF PROGRAM Hebrew Educational Society of Brooklyn 2021-2022

CHILD'S LAST NAME _____ FIRST NAME _____ BIRTHDATE / / SEX M☐ F☐

Home Address: _____ Phone: _____

Parent or Guardian: _____ Phone: _____

Place of Employment: Father (Guardian) _____ Phone: _____

Mother (Guardian) _____ Phone: _____

In case of emergency, notify: _____ Phone: _____

If Parent, Guardian are not available in an emergency, notify:

1. _____ Phone: _____

or 2. _____ Phone: _____

Important: Has this camper been exposed to any communicable disease during the three weeks prior to camp attendance:
Yes ☐ No ☐ (If yes, state type of exposure: _____)

HEALTH HISTORY: (Check box if child has had afflictions, give appropriate dates)

- ☐ Rheumatic Fever _____
- ☐ Seizures _____
- ☐ Diabetes _____
- ☐ Asthma _____
- ☐ Chicken Pox _____

Allergies

- ☐ Hay Fever _____
- ☐ Poison Ivy, etc. _____
- ☐ Insect Stings _____
- ☐ Penicillin _____
- ☐ Other Drugs _____
- ☐ Food _____

Other Past Illnesses _____

Operations or Serious Injuries (Dates) _____

Hospitalization (Dates) _____

Chronic or Recurring Illness _____

Any specific activities to be encouraged? _____

Conditions that require activity to be restricted? _____

Permission for all program activities unless otherwise noted by Dr. _____

Appliance worn (glasses, contacts, etc.) _____

Medication taken _____

Suggestion from Parent/Guardian _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I do hereby give authority to the Day Camp and Year Round Afterschool and Youth Center Program staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Relationship _____ Signature _____ Date _____ Tel.# _____

Department of Health and Mental Hygiene — The City of New York — Bureau of Food Safety and Community Sanitation

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	☐ 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

	Nl	Abnl
☐ Psychosocial Development	☐	☐
☐ Language	☐	☐
☐ Behavioral	☐	☐
☐ HEENT	☐	☐
☐ Dental	☐	☐
☐ Neck	☐	☐
☐ Lymph nodes	☐	☐
☐ Lungs	☐	☐
☐ Cardiovascular	☐	☐
☐ Abdomen	☐	☐
☐ Genitourinary	☐	☐
☐ Extremities	☐	☐
☐ Skin	☐	☐
☐ Neurological	☐	☐
☐ 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

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# ☐☐☐☐☐☐☐☐☐☐

OCFS-6040 (6/2020)

NEW YOK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD CARE EMPLOYEE, VOLUNTEER, PARENT, CHILD AND ESSENTIAL VISITORS HEALTH SCREENING ONE-TIME ATTESTATION

Before entering a child care program, employees, volunteers, parents, children and essential visitors ***must complete a health screening questionnaire daily. In addition, each employee, volunteer, parent, child and essential visitor must sign and submit this form to the program one time.*** Employees, volunteers, parents, children and essential visitors must answer all questions and take their temperature daily to confirm a body temperature lower than 100.0 degrees Fahrenheit. If anyone answers "Yes" to any of the questions below, they cannot enter the child care program. A parent or guardian is responsible for completing daily screening on behalf of their child(ren).

Self-Screening:

Below are the self-screening questions that employees, volunteers, parents, children and essential visitors are required to answer **daily**. If any of the answers to the below questions are "Yes," individuals **cannot** enter the program. If the answers are "No" to all the following questions, individuals may enter the program. If employees, volunteers, parents, children and essential visitors cannot take their temperature at home, but answer "No" to all other questions, they may report to the program to have their temperature taken on site.

1. Is your temperature higher than or equal to 100.0 degrees Fahrenheit?
2. Have you had any known contact with a person confirmed or suspected to have COVID-19 in the past 14 days?
3. Are you currently experiencing *ANY* of the following symptoms?
   - o Cough (new or worsening)
   - o Shortness of breath (new or worsening)
   - o Trouble breathing (new or worsening)
   - o Fever
   - o Chills
   - o Muscle pain (new or worsening)
   - o Headache (new or worsening)
   - o Sore throat (new or worsening)
   - o New loss of taste
   - o New loss of smell
4. Have you tested positive for COVID-19 through a diagnostic test in the past 14 days?

If you have answered "NO" to all questions, you have passed and may enter the program.

If you have answered "YES" to any question, you will not be allowed to enter the program.

Attestation: By signing this document, I agree that I will self-monitor these symptoms each day and report the outcome per the instructions above and will not enter any child care program if any of the above symptoms or conditions are present.

Signature	Date / /
Signature	Date / /

Note: *This document must be signed and returned to the program prior to entry. A signed copy needs to be provided only once. The child care program must retain a copy for their records.*

HEBREW EDUCATIONAL SOCIETY
9502 SEAVIEW AVENUE BROOKLYN, NEW YORK 11236
T: 718.241.3000 | F: 718.241.3349 THEHES.ORG

Assumption of the Risk and Waiver of Liability

Relating to Coronavirus/COVID-19

The coronavirus (COVID-19), has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and can spread from person-to-person contact. The Hebrew Educational Society of Brooklyn has and will continue to use its best efforts to institute and implement preventative measures to reduce the spread of COVID-19; however, the Hebrew Educational Society of Brooklyn cannot guarantee that you or your child(ren) may not become infected, exposed or otherwise contract COVID-19 while attending, participating in or otherwise engaging in any activities at or in connection with the Hebrew Educational Society of Brooklyn.

By signing this waiver and release, I acknowledge and agree that I, on my behalf and on behalf of my children: a) understand the contagious nature of COVID-19; b) voluntarily assume the risk that me, my child(ren) or anyone for whom I may be responsible may become infected, exposed or otherwise contract COVID-19 while attending, participating in or otherwise engaging in any activities at or in connection with the Hebrew Educational Society of Brooklyn; and c) hereby waive, release and discharge the Hebrew Educational Society of Brooklyn from and against any and claims or injuries arising out of, relating to or in any way connected to COVID-19 and the subject of this Waiver and Release.

_____ _____

Name of Participant Signature of Participant

_____

Date

If you have a child under age 18 attending Hebrew Educational Society of Brooklyn for any purpose, please complete the following:

_____ _____

Name of Child **Signature of Parent/Legal Guardian**

_____

Date

PARENT TO SCHOOL OFFICE PERMISSION LETTER

Dear Sir or Madam,

This is to inform you that my child, _____ of class _____ will be attending the After School Program at the Hebrew Educational Society for the 2021-2022 school term.

Please dismiss this child with the regular bus children at the end of the school day to the H.E.S. bus counselor.

Thank you for your attention to this matter. If you have any questions, please call the H.E.S. at 718-241-3000 ext. 131 and ask for our After School Program Staff.

Parent's Signature: _____

Date: _____

9502 Seaview Avenue, Brooklyn, NY 11236 Phone: 718-241-3000 ext. 131 Fax: 718-241-3349

PARENT TO TEACHER PERMISSION LETTER

Dear Sir or Madam,

This is to inform you that my child, _____ of class _____ will be attending the After School Program at the Hebrew Educational Society for the 2021-2022 school term.

Please dismiss this child with the regular bus children at the end of the school day to the H.E.S. bus counselor.

Thank you for your attention to this matter. If you have any questions, please call the H.E.S. at 718-241-3000 ext. 131 and ask for our After School Program Staff.

Parent's Signature: _____

Date: _____

9502 Seaview Avenue, Brooklyn, NY 11236 Phone: 718-241-3000 ext. 131 Fax: 718-241-3349