

Parent / Guardian Information

59. Last Name

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60. First Name

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61. Middle

--	--

62. Street Address (number and street)

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63. Apt #

--	--	--	--	--

64. Zip Code

--	--	--	--	--	--

65. Borough Code

1. Bronx 2. Brooklyn 3. Manhattan 4. Queens 5. Staten Island

66. Birth Date:

Month

Day

Year

67. Home Phone Number

(Area code)

68. Work Phone

(Area code)

69. Cell / Pager Number

70. Email Address:

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71. Ethnicity

1. American Indian

2. Asian (Non-Hispanic)

3. Black (Non-Hispanic)

4. Hispanic/Latino

5. Pacific Islander

6. White (Non - Hispanic)

7. Other

72. Relationship to applicant

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73. Primary Language Spoken

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74. English Proficient

Yes

No

Additional Parent / Guardian Information

75. Last Name

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76. First Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

77. Middle

--	--

78. Street Address (number and street)

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1. Bronx 2. Brooklyn 3. Manhattan 4. Queens 5. Staten Island

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88. Relationship to applicant

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89. Primary Language Spoken

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90. English Proficient

Yes

No

Health Information

91. Please check any box that applies to your child:

	YES	NO
Allergies to food (please specify):	<input type="checkbox"/>	<input type="checkbox"/>
Allergies to medicine (please specify) :	<input type="checkbox"/>	<input type="checkbox"/>
Allergies Other (please specify):	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral/Emotional issues	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Corrective Device (glasses, hearing aid, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Individualized Education Plan	<input type="checkbox"/>	<input type="checkbox"/>
Physical Disabilities	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify):	<input type="checkbox"/>	<input type="checkbox"/>

Children who have special health care needs are those who have chronic physical, developmental, behavioral, or emotional conditions expected to last 12 months or more and who also require health and related services of a type beyond that are required by children generally. If your child does have special health care needs please discuss these with your child care provider.

Please explain: _____

92. Does your child have special health care needs that require treatment and/or medication? YES NO

Please explain: _____

93. Does your child take medication for any condition or illness? YES NO

Please explain: _____

94. Are there any activities your child cannot participate in? YES NO (if yes, please specify)

Please explain: _____

CERTIFICATION STATEMENT

I, the undersigned, certify that all information on this form is true and correct. I understand that my statements are subject to verification. I agree and accept that I will abide by all applicable rules and regulations of this program. I consent to the enrollment and participation of the child listed above in this program.

Applicant Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Intake Officer Signature _____ Date _____

DYCD EMERGENCY MEDICAL CARE (To be completed by the parent or guardian)

Student's Name: _____ **Date of Birth:** _____

1. If my child requires emergency medical care and I cannot be reached, I give my consent to the above after-school program to obtain the necessary medical care for my child. I agree to pay all of the costs associated with the emergency medical care that my child receives. I understand that every effort will be made to contact me before and after medical care is provided.

2. Following emergency medical care, my child may be released to the following people:

Name: _____	Relationship to Child: _____
Address: _____	Employer: _____
Home Phone: _____	Work Phone: _____

Name: _____	Relationship to Child: _____
Address: _____	Employer: _____
Home Phone: _____	Work Phone: _____

Name: _____	Relationship to Child: _____
Address: _____	Employer: _____
Home Phone: _____	Work Phone: _____

3. Health/Insurance Information:

Student's Doctor: _____	Insurance Company: _____
Phone: _____	Policy Holder's ID: _____
Allergies: _____	Religious Preference: (optional) _____
Last Tetanus: _____	Medication(s) being taken: _____
Address (student's doctor): _____	

Additional Comments: _____

4. I understand that this consent will be in effect as of the date of my signing this form and will continue as long as my child is enrolled in this after-school program.

Parent/Guardian Signature

Date

**Rhinelander Children's Center
Saturday Program for Deaf and Hard of Hearing
Children and Teens**

**Parent Consent to Participate in the Evaluation of the
Out of School Time After-School Program**

Dear Parent,

Your child, _____, is enrolled in the Saturday Program at Rhinelander, which is supported by Department of Youth and Community Development (DYCD). In order to monitor the effectiveness of the after school program and ensure its future success, DYCD is conducting an ongoing evaluation. It is the intention of the evaluation to learn how these services help students and how they can be improved in order to meet the grant requirements.

Specifically we ask permission from parents to:

- Contact their children's school and obtain records showing their progress, including information about enrollment, grades, citywide and statewide test scores, and attendance.
- Talk to teachers and after-school staff about children's progress and participation in the after-school program, and review program records on participation in the after-school program.
- Survey and/or interview parents and children about the after-school program and its effects.

Any information we collect will be used only to assess the after-school program and will not be made public. Participating in the evaluation will not affect your child in school, in the after-school program, or in any other way. We will not use your name or your child's name in any report. At the end of the evaluation, we will destroy all records that include personal information. Participation in the study is completely voluntary and participants may withdraw at any time with no consequences.

Please select one of the options below and return this form to the program coordinator/director.

YES, I GIVE PERMISSION FOR MY CHILD TO PARTICIPATE. I have read the above information and I give permission for my child to participate in the evaluation of the after-school program. I also consent for DYCD to obtain my child's records and to interview program and school staff for evaluation purposes.

Signature

Date

*NO, I DO NOT WANT MY CHILD TO PARTICIPATE. I have read the above information and I **DO NOT** give permission for my child to participate in the evaluation of the after-school program.*

Signature

Date

If you have any questions about the evaluation contact the after school site coordinator.

Rhinelanders Children's Center
Saturday Program for Deaf and Hard of Hearing
Children and Teens

PHOTO/VIDEO/INTERVIEW CONSENT (To be completed by the parent or guardian)

I certify that I am the parent or legal guardian of _____,
whose date of birth is _____. _____ name of child
month/day/year

I understand that this after-school program features special events both in-school and away from school. Media representatives, newspaper and television reporters, photographers, and public-relations personnel may be present at these special events to record them. In some cases they may interview and/or photograph children who participate in these events. These photographs, videos, and interviews will only be used to promote this after-school program.

I give permission for my child to be photographed or otherwise recorded during after-school events and activities, and for any and all such photographs to be displayed by The Rhinelanders Children's Center Saturday Program for Deaf and Hard of Hearing Children and Teens or The Department of Youth and Community Development in any medium (books, newsletters, web sites, etc.), whether now or hereafter known or developed.

SIGNATURE OF PARENT OR GUARDIAN

DATE

If you do not wish for your child to participate in the activities described above, please review this section of this form.

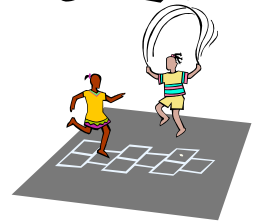
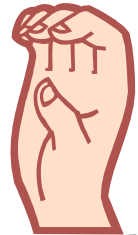
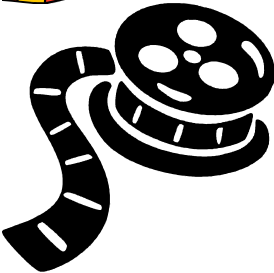
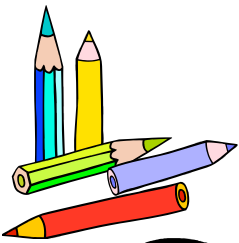
I DO NOT give permission for my child to be photographed or otherwise recorded during after-school events and activities. As a result, my child may not be able to participate in these events and activities.

SIGNATURE OF PARENT OR GUARDIAN

DATE



The Children's Aid Society
Rhineland Children's Center
350 East 88th Street-New York, NY 10128
Phone: (212) 876-0500 Fax: (212) 876-9718
www.rhinelandcenter.org
Email: DeafSatProgram@aol.com



SATURDAY PROGRAM FOR DEAF
& HARD OF HEARING CHILDREN AND
TEENS

PROGRAM DATES 2008-2009

SEPTEMBER 13th & 27th

OCTOBER 4th & 18th

NOVEMBER 1st & 15th

DECEMBER 6th & 13th

JANUARY 10th & 24th

FEBRUARY 7th & 28th

MARCH 14th & 28th

APRIL 4th & 25th

MAY 9th & 30th

JUNE 13th & 20th

PROGRAM TIMES

10:00-3:00 PM

CHILDREN IN GROUPS 1, 2, & 3 MUST
ALWAYS BRING LUNCH

TEENS IN TEEN GROUP BRING LUNCH OR
MONEY TO BUY LUNCH

PICK-UP IS AT 3:00 PM PROMPTLY!



The Children's Aid Society
Rhinelander Children's Center
350 East 88th Street New York, NY 10128
Phone: (212) 876-0500 Fax: (212) 876-9718
www.rhinelandercenter.org

July 2008

Dear Parent or Guardian,

WELCOME back to another FUN & EXCITING year at Rhinelander's Saturday Program for Deaf and Hard of Hearing Children and Teens.

There has been an addition to our application this year. We now require each of our participants to have an up-to-date health form with a doctor's signature on file. Enclosed is a copy of this form. We ask that you have your doctor or health care professional fill it out and return it to the Rhinelander Children's Center by the first day of the program on September 13, 2008. Please keep a copy of this form for your records and fax a copy to (212) 876-9718 or mail it to:

**Saturday Program
Rhinelander Children's Center
350 E. 88th Street
New York, New York 10128**

If your child has a different form that needs to be completed for his/her school, we can accept copies of that form instead of this one. Your child cannot attend the Saturday Program unless we have a signed health form on file.

If you have any questions, please feel to call us at (212) 876-0500 (v) or email Suling Miller, Saturday Program Coordinator, at sulingm@childrensaidsociety.org.

Thank you in advance for your assistance.

Sincerely,

Karen M. Solomon, Director
Saturday Program

Suling Miller
Saturday Program Coordinator

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 _____

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

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)

Allergies

- | | |
|--|---|
| <input type="checkbox"/> Rheumatic Fever _____ | <input type="checkbox"/> Hay Fever _____ |
| <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Poison Ivy, etc. _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Insect Stings _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Penicillin _____ |
| <input type="checkbox"/> Chicken Pox _____ | <input type="checkbox"/> Other Drugs _____ |
| | <input type="checkbox"/> 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.# _____

PHYSICAL EXAMINATION

(To be filled out by Physician – please note information on reverse side)

The purpose of this health record is to provide the staff with pertinent information which will help to serve the needs of this child in Day Camps and Afterschool and Youth Center programs.

IMMUNIZATION HISTORY – This is a record of dates of basic immunization and most recent booster doses.

DTaP, DTP, DT, Td	Date _____	Date _____	Date _____	Date _____	Date _____
Polio	Date _____	Date _____	Date _____	Date _____	Date _____
MMR	Date _____	Date _____	Date _____		
Hemophilus Influenzae type b (Hib)		Date _____	Date _____	Date _____	Date _____
Hepatitis B	Date _____	Date _____	Date _____	Date _____	
Varicella	Date _____	Date _____			
Pneumococcal Conjugate (PCV)	Date _____	Date _____	Date _____	Date _____	Date _____
Other _____	Date _____	Other _____	Date _____	Other _____	Date _____

MEDICAL EXAMINATION – To be filled out by licensed physician.

Examination is acceptable when performed no more than 12 months prior to arrival at camp.

Code: S = Satisfactory

X = Not Satisfactory (Explain)

0 = Not Examined

General Appearance _____

Genitalia _____

Height _____ Weight _____ Blood Pressure _____ Posture & Spine _____ Throat - Tonsils _____

Nose _____ Teeth _____ Abdomen _____ Hernia _____ Feet _____ Lungs _____ Skin _____

Hgb. Test (Date) _____ Urinalysis (Date) _____

Eyes _____ Vision _____ w/Glasses _____ Extremities _____ Heart _____

Ears _____ Hearing _____

Neurological Findings _____

Describe Abnormal Findings and/or Handicapping Conditions _____

Allergy: (Please specify) _____

Recommendations and restrictions while in camp:

Special Diet _____

Special Medicine (dose, route of administration, when should it be administered) _____

Is parent/guardian sending special medicine? _____

Activity Restrictions _____

Swimming _____ Diving _____

General Appraisal: _____

I have examined the person herein described, reviewed his/her health history and it is my opinion that he/she is physically able to engage in Day Camp/Year Round Afterschool and Youth Center activities, except as noted above.

M.D.

EXAMINING PHYSICIAN (SIGNATURE)

PHYSICIAN'S NAME (PLEASE PRINT)

Telephone _____ Address _____

Date of Examination _____

ZIP CODE