United Activities Unlimited, Inc.
P.O. Box 140707
Staten Island, New York 10314-0707
Registration Information Form

Student's Name: _____ Date of Birth: _____
First Middle Last Mo/Day/Year

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 cost 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.

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

Name: _____ Relationship to Child_____
Address: _____ Employer: _____
Home Phone: _____ Work/Cell Phone: _____

Name: _____ Relationship to Child_____
Address: _____ Employer: _____
Home Phone: _____ Work/Cell Phone: _____

Name: _____ Relationship to Child_____
Address: _____ Employer: _____
Home Phone: _____ Work/Cell Phone: _____

Health Insurance Information:

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

Additional Comments: _____

_____

I understand that his 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

Health Information

Please check any box that applies to your child

	YES	NO		YES	NO
Allergies to food (please specify)	☐	☐	Convulsions Seizers	☐	☐
Allergies to medicine (please specify)	☐	☐	Corrective Device (glasses, hearing, aid etc.)	☐	☐
Allergies Other (please specify)_____	☐	☐	Diabetes	☐	☐
Asthma	☐	☐	Individualized Education Plan	☐	☐
Behavioral/Emotional issues	☐	☐	Physical Disabilities	☐	☐
Other (please specify)					

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 childcare provider.

Please explain:_____

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

Please explain:_____

Does your child take medication for any condition or illness ☐YES ☐ NO

Please explain:

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. I understand that if my child has a seizure or any other anticipated medical reaction while attending this program, I will not hold UAU responsible.

_____ _____

Applicant Signature Date Parent/Guardian Signature Date

_____

Teacher in Charge

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly Press Hard

STUDENT ID NUMBER OSIS

TO BE COMPLETED BY 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** Last Name First Name ☐ **Foster Parent**

TO BE COMPLETED BY HEALTH CARE PROVIDER *If "yes" to any item, please explain (attach addendum, if needed)*

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF/Asthma Action Plan):* ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Inhaled corticosteriod ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ 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)*
☐ **Other** *(specify)* _____

Explain all checked items above or on addendum

Medications ***(attach MAF if in-school medication needed)***

☐ None ☐ Yes *(list below)*

_____

_____

Dietary Restrictions

☐ None ☐ Yes *(list below)*

_____

PHYSICAL EXAMINATION

Height _____ **cm** (___ ___ %ile)

Weight _____ **kg** (___ ___ %ile)

BMI _____ **kg/m²** (___ ___ %ile)

Head Circumference *(age ≤2 yrs)* _____ **cm** (___ ___ %ile)

Blood Pressure *(age ≥3 yrs)* _____ / _____

General Appearance:

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

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)* ☐ Within normal limits

If delay suspected, specify below

☐ Cognitive *(e.g., play skills)* _____

☐ Communication/Language _____

☐ Social/Emotional _____

☐ Adaptive/Self-Help _____

☐ Motor _____

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
Hearing ☐ Pure tone audiometry ☐ OAE	__ __ / __ __ / __ __	☐ Normal ☐ Abnormal
Head Start Only		
Hemoglobin or Hematocrit *(age 9–12 mo)*	__ __ / __ __ / __ __	_____ g/dL _____ %

	Date Done	*Results*
Tuberculosis *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school*		
PPD/Mantoux *placed*	__ __ / __ __ / __ __	Induration _____mm
PPD/Mantoux *read*	__ __ / __ __ / __ __	☐ Neg ☐ Pos
Interferon Test	__ __ / __ __ / __ __	☐ Neg ☐ Pos
Chest x-ray *(if PPD or Interferon positive)*	__ __ / __ __ / __ __	☐ Nl ☐ Abnl ☐ Not Indicated
Vision *(required for new school entrants and children age 4–7 yrs)*	__ __ / __ __ / __ __ ☐ with glasses	Acuity *Right* ___ / ___ *Left* ___ / ___ Strabismus ☐ No ☐ Yes

IMMUNIZATIONS – DATES CIR Number of Child

Hep B __ __ / __ __ / __ __ __ __ / __ __ / __ __ __ __ / __ __ / __ __ __ __ / __ __ / __ __

Rotavirus __ __ / __ __ / __ __ __ __ / __ __ / __ __ __ __ / __ __ / __ __

DTP/DTaP/DT __ __ / __ __ / __ __ __ __ / __ __ / __ __ __ __ / __ __ / __ __

__ __ / __ __ / __ __ __ __ / __ __ / __ __ __ __ / __ __ / __ __

Hib __ __ / __ __ / __ __ __ __ / __ __ / __ __ __ __ / __ __ / __ __

PCV __ __ / __ __ / __ __ __ __ / __ __ / __ __ __ __ / __ __ / __ __

Polio __ __ / __ __ / __ __ __ __ / __ __ / __ __ __ __ / __ __ / __ __

Influenza __ __ / __ __ / __ __ __ __ / __ __ / __ __ __ __ / __ __ / __ __

MMR __ __ / __ __ / __ __ __ __ / __ __ / __ __ __ __ / __ __ / __ __

Varicella __ __ / __ __ / __ __ __ __ / __ __ / __ __

Td __ __ / __ __ / __ __ __ __ / __ __ / __ __ __ __ / __ __ / __ __

Tdap __ __ / __ __ / __ __ Hep A __ __ / __ __ / __ __ __ __ / __ __ / __ __

Meningococcal __ __ / __ __ / __ __ __ __ / __ __ / __ __

HPV __ __ / __ __ / __ __ __ __ / __ __ / __ __ __ __ / __ __ / __ __

Other, *specify:* _____ __ __ / __ __ / __ __ ; _____ __ __ / __ __ / __ __

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet

☐ Restrictions (*specify*) _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: __ __ / __ __ / __ __

Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision

☐ Other _____

ASSESSMENT ☐ **Well Child** (V20.2) ☐ **Diagnoses/Problems** *(list)* **ICD-9 Code**

_____ __ __ __ __

_____ __ __ __ __

_____ __ __ __ __

Health Care Provider Signature | Date __ __ / __ __ / __ __

Health Care Provider Name and Degree *(print)* | Provider License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (__ __ __) ___ ___ ___ – ___ ___ ___ ___ | Fax (__ __ __) ___ ___ ___ – ___ ___ ___ ___

DOHMH ONLY **PROVIDER I.D.**

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments

Date Reviewed: __ __ / __ __ / __ __ | I.D. NUMBER

REVIEWER:

CH-205 (5/08)

Copies: **White** School/Child Care/Early Intervention/Camp, **Canary** Health Care Provider, **Pink** Parent/Guardian