United Activities Unlimited, Inc.
1200 South Avenue Suite 304
Staten Island, New York 10314
Phone: 718-987-8111 Ext. 820
Fax: 718-981-7152
https://unitedactivities.org/CAAT/

Registration Form/or 2024-2025
Children's Activities After Three Program

***Please email completed applications to caatpayments@unitedactivities.org**

☐ Payment was submitted online via Paypal ☐ Money order enclosed

*School*____________ *Grade*_______ *Class*__________ *Date Child Will Begin*_______________

*Last Name*_________________________________*First Name*___________________________

*Home Address*____*Zip*_________________

*Home Phone*____________________________________ *Other #*_________________________

*Mother's Name*__________________________________ *Cell #*__________________________

*Name of Employer*_______________________________ *Work #*__________________________

*Employer's Address*____*Zip*________________

*Father's Name*__________________________________ *Cell #*___________________________

*Name of Employer*_______________________________ *Work #*__________________________

*Employer's Address*____*Zip*________________

*E-mail address*____

Emergency Contact Persons or Designee

*Name*______________________________________*Phone #*_____________________________

*Address*_________________________*Zip*_________*Relationship*________________________

*Name*______________________________________*Phone #*_____________________________

*Address*_________________________*Zip*_________*Relationship*________________________

If no emergency person can be reached and we feel it is in the best interest of the child to seek medical help, we will call an ambulance to transport your child to the nearest hospital unless otherwise instructed. United Activities Unlimited, Inc. does not administer medicine to children as per School Age Child Care regulations. We are not required to have a nurse on staff, so if your child uses an inhaler they must be responsible for keeping it in a safe place and know when and how to use the instrument. We do not dispense any kind of medicine.

Parent/Guardian Signature:__________________________________

***Online payments and money orders are the only acceptable forms of payment.**
Please write your child's name & school on all money orders.*

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CAAT Registration Information Form

Student's Name: ______________________________________ Date of Birth: ________________
First Middle Last Month/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 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

Health Information

Please check any box that applies to your child

	YES	NO		YES	NO
Allergies to food (please specify)	☐	☐	Convulsions Seizures	☐	☐
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

Please Print Clearly Press Hard

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

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** ☐ **Foster Parent** Last Name | First Name

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

DOHMH ONLY **PROVIDER I.D.**

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

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

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

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

Telephone (___) ___ – ____ | Fax (___) ___ – ____

REVIEWER:

CH-205 (5/08)

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