BumbleBeesRus

EDUCATIONAL CHILD CARE PROGRAMS

Summer Program

After School Program

Enrollment Packet

76 LORRAINE ST. • Brooklyn, NY 11231
(718) 858-8111

BumbleBeesRus.com

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76 Lorraine Street
Brooklyn, NY 11231
(718) 858-8111
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Welcome to BumbleBeesRus!

Dear Parents and Guardians,

First and foremost, thank you for choosing BumbleBeesRus as your Summer Program/ After School provider. We are excited to welcome you to the BumbleBeesRus family! Our main goal at BumblebeesRus is to provide your child with the best care possible in a safe, nurturing, and fun environment.

In this Enrollment Packet, you will find all the forms that you need for your child's enrollment at BumbleBeesRus. Also included in this packet is important information such as contact numbers, medical requirements, calendar of events, and other documents that you will need to have signed to complete your child's enrollment. For your convenience, the Enrollment Packet is available online at www.BumbleBeesRus.com and some forms can be downloaded and easily filled out or printed using the Acrobat PDF.

Please do not hesitate to contact us should you have any questions regarding your child's care. Thank you and BumbleBeesRus looks forward to providing your child with a wonderful home away from home.

Warm Regards,

The BumbleBeesRus Administration
Phone: (718) 858-8111

Enrollment Application Form

Summer/After School Program

Child Information: Child's Name: _____ DOB: _____

Nickname: _____ Social Security #: _____ Gender: ☐ Male ☐ Female

Primary Home Address: _____

Child's Primary Residence (check one): ☐ Mother ☐ Father ☐ Both ☐ Guardian

Child's Race (optional – check all that apply):

☐ *American-Indian or Alaskan Native* ☐ *Asian* ☐ *Black or African-American* ☐ *Native Hawaiian/Other Pacific Islander*

☐ *White* ☐ *Multi or Bi-racial* ☐ *Other* ☐ *Unspecified*

Hispanic: ☐ *Yes* ☐ *No*

Child's Primary Language: _____ Proficiency (check one): ☐ *Little* ☐ *Moderate* ☐ *Proficient*

Child's Secondary Language: _____ Proficiency (check one): ☐ *Little* ☐ *Moderate* ☐ *Proficient*

Summer Program: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

After School Program: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Parent/Guardian Information:

Parent 1/Guardian's Name: _____ DOB: _____

E-mail Address: _____ Home# _____ Cell Phone#: _____

Text Messaging: (Please initial)

_____ *I hereby permit BumbleBeesRus to text message my cell phone number only when important announcements must be communicated, such as emergencies, school closing, and other events that will affect my child's care.*

Place of Employment: _____ Work #: _____

Parent/Guardian Marital Status (check one): ☐ *Single* ☐ *Married* ☐ *Separated* ☐ *Divorced* ☐ *Widowed]*

Parent 2/Guardian's Name: _____ DOB: _____

E-mail Address: _____ Home# _____ Cell Phone#: _____

Text Messaging: (Please initial)

_____ *I hereby permit BumbleBeesRus to text message my cell phone number only when important announcements must be communicated, such as emergencies, school closing, and other events that will affect my child's care.*

Place of Employment: _____ Work #: _____

Parent/Guardian Marital Status (check one): ☐ *Single* ☐ *Married* ☐ *Separated* ☐ *Divorced* ☐ *Widowed*

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Funding Stream: ***(to be completed by BumbleBeesRus staff)***

☐ HRA: New case? Date application submitted: _____

Existing case? Case # _____ Recertification Date: _____

☐ Private Pay

Tuition Agreement Form

Child's Name: _____ DOB: _____

Parent/Guardian Name(s) : _____

Tuition Agreement

☐ **Private**: I understand that my child's tuition is an ongoing weekly fee and I am responsible for my child's tuition amount based on his/her scheduled days, regardless of any days my child is ill, on vacation, or does not attend for any other reason.

☐ **HRA**: I understand that my child's co-pay is an ongoing weekly fee and I am responsible for my child's co-payment based on the HRA form. If my child attends for one day out of the week I am still responsible to pay the weekly fee.

☐ **All Funding Streams**: I understand that tuition is due on the Friday before each new month/week begins. I am aware that all payments need to be received by the Summer Program/After School Director.

Payment Schedules

☐ **Private**: Late payments and Non-Payments: I understand that payments made after the tenth of the day of the month are considered late and a late fee of $35 will be assessed. I am aware that if the 10th day of the month falls on a weekend/holiday the last day tuition can be paid without a late fee if the last day the center is open before the holiday/weekend.

☐ **All Funding Streams**: Returned Checks: I understand that if my tuition check is returned for any reason, I will be charged a processing fee of $25.00. I understand that if BumbleBeesRus receives two or more returned checks from my family, they will no longer accept checks as a method of payment.

☐ **All Funding Streams**: Delinquent Accounts: I understand that if accounts continue to be delinquent, the Center has the right to discontinue services.

BumbleBeesRus does not discriminate based on disability in the admission/access to our program.

I understand and agree with all the aforementioned terms listed in the Tuition Agreement.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Enrollment Coordinator Signature: _____ Date: _____

Dear Parent, Guardian or CACFP Participant,

This center participates in the Child and Adult Care Food Program (CACFP) and provides healthy meals at no cost to all children and adults enrolled in the daycare center. By completing and returning the attached Income Eligibility Form, you will help your center receive money from CACFP for the meals that are served. If your household's income is equal to or less than the amounts indicated for your household size on the chart below, the center will receive a higher rate of funding for the meals served. The Income Eligibility Form needs to be completed every year. Your center and CACFP will keep all information private.

INCOME ELIGIBILITY GUIDELINES
(Effective July 1, 2020 until June 30, 2021)

HOUSEHOLD SIZE	REDUCED-PRICE MEALS		
	YEAR	MONTH	WEEK
1	23,606	1,968	454
2	31,894	2,658	614
3	40,182	3,349	773
4	48,470	4,040	933
5	56,758	4,730	1,092
6	65,046	5,421	1,251
7	73,334	6,112	1,411
8	81,622	6,802	1,570
FOR EACH ADDITIONAL FAMILY MEMBER	+8,288	+691	+160

SPONSOR/CENTER OFFICIAL | SPONSORING ORGANIZATION | DATE

This institution is an equal opportunity provider.

NEW YORK STATE DEPARTMENT OF HEALTH
Child and Adult Care Food Program

Income Eligibility Form
for Child Care Centers

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME _____

Print the name of the child(ren) enrolled in this child care center

1. _____ 2. _____ 3. _____

DIRECTIONS

Complete SECTION A if anyone in your household
1. Participates in the Supplemental Nutrition Assistance Program (SNAP)
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR) OR
4. Is a foster child

SECTION A

SNAP Case # _____

TANF # _____

FDPIR # _____

Names of Foster Children _____

_____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true. I understand that the center will get Federal funds based on the information I give.

Signature _____

Date _____

FOR SPONSOR USE ONLY

CACFP Agreement # _____

Total Number of Household Members _____
(INCLUDING FOSTER CHILDREN, IF APPLICABLE)

Total Household Income $ _____

Free _____ Reduced _____ Paid _____

Date of Determination _____

Signature of Center Staff _____

Complete SECTION B if no one in your household participates in SNAP, receives TANF, participates in FDPIR or if none of the children enrolled in the child care center is a foster child.

SECTION B

List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received **last month** in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, child support, foster child's personal income and any other sources of income.

HOUSEHOLD MEMBER NAME	MONTHLY GROSS SALARY
1. _____	$ _____
2. _____	$ _____
3. _____	$ _____
4. _____	$ _____
5. _____	$ _____
6. _____	$ _____
7. _____	$ _____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true and that all income is reported. I understand that the center will get Federal funds based on the information I give.

Signature _____

Print Name _____

LAST FOUR (4) DIGITS OF SOCIAL SECURITY NUMBER ☐☐☐☐

DATE _____

USDA is an equal opportunity provider and employer.

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this form. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the form. The Social Security Number is not required when you: apply on behalf of a foster child; provide a SNAP, TANF or FDPIR number; or when you indicate that the adult household member signing the form does not have a Social Security Number. We will use your information to determine if the center is eligible for free or reduced-price meal reimbursement and for administration and enforcement of the Program.

INSTRUCTIONS FOR COMPLETING DOH-3688

Definition of Income

Income means income before deductions for income taxes, social security taxes, insurance premiums, charitable contributions, and bonds, etc. It includes the following: (1) monetary compensation for services, including wages, salary, commissions or fees; (2) net income from non-farm self-employment; (3) net income from farm self-employment; (4) Social Security payments; (5) dividends or interest on savings or bonds, income from estates or trusts or net rental income; (6) unemployment compensation; (7) government civilian employee or military retirement, or pensions or veteran's payments; (8) private pensions or annuities; (9) alimony or child support payments; (10) regular contributions from persons not living in the household; (11) net royalties; (12) military benefits received in cash, such as housing allowance except if you are in the Military Housing Privatization Initiative; and (13) any other cash income.

Definition of Household

Household means *family* as defined in Section 226.2. *Family* means a group of related or non-related individuals who are not residents of an institution or boarding house, but who are living as one economic unit.

INSTRUCTIONS FOR PARENTS OR GUARDIANS

Write in the name of the child care center in the space provided.

Print the name of each child in your household who attends this child care center.

Section A: If anyone in your household participates in the Supplemental Nutrition Assistance Program (SNAP), receives Temporary Assistance for Needy Families (TANF) or participates in the Food Distribution Program on Indian Reservations (FDPIR), complete Section A only. Write down the SNAP, TANF or FDPIR number (do not use your ACS or DSS child care subsidy number). Then sign and date the form and return it to the day care center.

Foster children: If your household includes a foster child who is in child care, write in the names of the foster children.

Section B: Complete this section if you did not complete Section A. Write in your name and the names of all other adults and children living in the household, including unrelated people, even if they do not have any income. Do not include the children in child care who are listed at the top of the form.

Enter the amount of income each person received **last month**, before taxes or anything else was taken out. Refer to the Definition of Income and the Definition of Household, above. If any amount last month was more or less than the usual, write in that person's usual income.

The last four digits of the Social Security Number of the adult signing the certification is required. If you do not have a Social Security Number, write *none*. The form must be signed by an adult member of the household.

INSTRUCTIONS FOR CENTERS AND SPONSORS

The *For Sponsor Use Only* section is to be completed, signed and dated by center or sponsor staff. The sponsor/center representative must review the income eligibility form and ensure that it is completed as indicated in the instructions above. Then indicate the following:

The CACFP Agreement Number.

Total Number of Household Members – This item does not have to be completed if the parent completed Section A. Add those indicated in Section B (if completed) to the children enrolled in child care and the number of foster children, if applicable.

Total Household Income – This item does not need to be completed if the parent completed Section A. Indicate the total monthly income as calculated from Section B. If the parent chooses not to disclose income, the form must be categorized as *paid.*

Number of Free, Reduced or Paid – Compare the total household income and the total number of household members with the current year's Income Eligibility Guidelines (CACFP-3687) to determine if the household should be categorized as **Free, Reduced** or **Paid**. Use the appropriate column on the CACFP-3687 to categorize their income. For example, if the parent indicated biweekly income, multiply this amount by 26 to determine yearly income.

Incomplete forms (missing signatures, income information, last four digits of Social Security Number or SNAP, TANF or FDPIR numbers) are categorized in the paid category.

The income eligibility form is valid until the last day of the month one calendar year from the date it is signed by the household member. For example, a form signed on May 12, 2014 is valid until May 31, 2015.

Daily Procedures Agreement

Child's Name: _____ DOB: _____

Parent/Guardian Name(s) : _____

Please initial each item below:

_____ I agree to sign the school attendance log when my child arrives in the morning and again when he/she is picked up at the end of the day. No one under the age of 16 is allowed to sign my child in/out of the school.

_____ **Illness**: I understand that I will be notified by school personnel if my child becomes ill during the day and I agree to make every effort to have my child picked up in a timely manner, as the health and safety of all children is of the utmost importance. If my child is exposed to or contracts a contagious disease, I agree to notify the school and I will make certain that he/she does not return to school without written permission from my child's doctor.

_____ **Withdrawal from BumbleBeesRus**: I have the right to withdraw my child from the program at any time; however, I understand that I must provide a 2 week written notice of withdrawal. If this written notification is not received I agree to pay all the tuition for the 2 week period. I understand that if I then choose to re-enroll my child, she/he will only be readmitted based upon space availability and at the current rate of tuition.

_____ At the Director's discretion, BumbleBeesRus has the right to ask a child to withdraw from our program.

_____ **Inclement Weather/School Closings**: I understand that it is the Day Cares' objective to be open during every regularly scheduled school day; however, there are some specific days during which the school will be closed (i.e. federal holidays). In addition, inclement weather and or natural/national disaster or major building issues may necessitate an immediate school closing. This will not affect my child's tuition in any way.

_____ **I understand that if I am late picking up my child on any given day, I will be charged a late fee of $1.00 per each minute that I am late *until my child is picked* up by myself or the appropriate contact listed. This late fee is to be paid immediately upon pick-up. If the lateness continues, I may be asked to remove my child from the Center permanently.**

I understand and agree with all the aforementioned terms listed in the Daily Procedures.

Parent/Guardian Signature: _____ Date:

Parent/Guardian Signature: _____ Date: _____

Enrollment Coordinator Signature: _____ Date: _____

Emergency Release and Authorized Escorts List

To maintain the safety of your children, Parents/Guardians must complete, sign, and return this form to BumbleBeesRus upon enrollment. This form shall be updated periodically or when there are changes in the Emergency Release and Authorized Escort information.

Child's Name: ______________________________ **DOB**: ____________________

Parent/Guardian: ______________________________ **Phone#**: ____________________

Parent/Guardian: ______________________________ **Phone#**: ____________________

Emergency Release Contacts:
Only individuals listed below will be considered as designated emergency release persons. Government issued ID will be required at time of pick up. All release persons must be above 16 years of age. Please submit a photo ID of all individuals listed below.

Non-emergency contact persons that are to be designated as release persons:
Only individuals listed below are authorized as designated release persons. Government issued ID will be required at time of pick up. All release persons must be above 16 years of age. Please submit a photo ID of all individuals listed below.

Name: ____________________
Relationship to Child: ____________________
Preferred Contact Information:
____
Home Address: ____________________
☐ *Emergency Release* ☐ *Non-Emergency Release*

Name: ____________________
Relationship to Child: ____________________
Preferred Contact Information:
____
Home Address: ____________________
☐ *Emergency Release* ☐ *Non-Emergency Release*

Name: ____________________
Relationship to Child: ____________________
Preferred Contact Information:
____
Home Address: ____________________
☐ *Emergency Release* ☐ *Non-Emergency Release*

Name: ____________________
Relationship to Child: ____________________
Preferred Contact Information:
____
Home Address: ____________________
☐ *Emergency Release* ☐ *Non-Emergency Release*

Name: ____________________
Relationship to Child: ____________________
Preferred Contact Information:
____
Home Address: ____________________
☐ *Emergency Release* ☐ *Non-Emergency Release*

Name: ____________________
Relationship to Child: ____________________
Preferred Contact Information:
____
Home Address: ____________________
☐ *Emergency Release* ☐ *Non-Emergency Release*

I, ______________________________, authorize this child care center to release my child,
(parent/guardian name)

______________________________, to the individuals I have identified above.
(child name)

Parent/Guardian Signature: ______________________________ Date: ____________________

Emergency Treatment Form

I (we) _____ hereby state that I/we are the legal guardian(s) of _____, DOB _____, who resides with me/us at _____.

I (we) authorize that for emergency purposes, a school designated employee may provide consent for my child to receive medical attention i.e. necessary examination, medical diagnosis, surgery, treatment, and/or EMS/hospital care. In the event that my child needs to be transported, a BumbleBeesRus staff member will accompany my child at all times. I understand that every effort will be made to contact the Emergency Contact persons provided in the Emergency Release Contact Form.

Health Insurance Information

Health Insurance Provider: _____ Policy #: _____

Policy Holder Name: _____ Dental Included? ☐ Yes ☐ No

Pediatrician: _____ Phone #: _____

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

Photo Consent Form

Child's Name: _____ DOB: _____

Parent/Guardian Name(s): _____

Photo Consent

Photos are taken regularly in our program to capture the fun activities that your child participates in. Photos are used for social media, the BumbleBeesRus website and other marketing materials. Please indicate your permission for consent and sign below.

Photos: (Please mark your answer where indicated)

Social media and company website (visible to the public) ☐ *Yes* ☐ *No*
Facebook, Twitter, etc

Printed Marketing Materials (visible to the public) ☐ *Yes* ☐ *No*
Flyers, brochures, magazines, advertisements, etc.

Parent Signature : _____ Date _____

Participant Agreement, Agreement to Indemnify, & Risk Acknowledgment

Child's Name: _____ DOB: _____

Parent/Guardian Name(s): _____

In consideration of the services of the BumbleBeesRus Summer/After School Program, as well as their agents, officers, participants, consultants, employees, and all persons or entities acting in any capacity on their behalf (hereinafter referred to as BBRU), I now agree to release & discharge BBRU on behalf of myself, my children, my parents, my family as follows:

1. I acknowledge the activities of this program entail known & unanticipated risks, which could result in physical or emotional injury, paralysis, death or damage to my child, to property or to third parties. I understand that such risks cannot be eliminated without jeopardizing the essential qualities of the program activities. In an effort to minimize those risks I agree to follow all safety requirements and make use of any safety equipment provided.

THE RISKS INCLUDE, BUT ARE NOT LIMITED TO:

A. Nature of the activities.
B. Latent or apparent defects or conditions in equipment or property supplied by BBRU or other persons or entity.
C. Use of property or equipment supplied by BBRU or other persons or entities by my child or others.
D. Acts of other participants in this program, employees or agents of BBRU.
E. My child's own physical condition, or own acts or omissions.
F. Conditions of BBRU's facility & surrounding grounds or terrain and accidents connected with their use.
G. First Aid emergency treatment or other services.

2. I expressly agree and promise to accept and assume all the risks existing in this program, on behalf of myself and my child. My child's participating in this program is purely voluntary and I elect to allow my child to participate in spite of the risks.

3. Both my child and I agree that when he or she is participating in the Program, that he or she will cooperate promptly and fully with all directions of BBRU's personnel. We also agree that he or she will follow all BBRU Rules and Regulations, and all applicable City of New York ("City"), New York State, and Federal laws, rules and regulations. We understand that her or his failure to behave appropriately may result in termination from the Program.

2. SUMMER SCHOOL AFTERSCHOOL RULES AND REGULATIONS:

A. Participation

Children are required to:

a) Adhere to all Summer/After School program Rules and Regulations.
b) Attend the Summer/After School program on a regular basis.
c) Respect all program staff and members.
d) Respect all children in the program.
e) Respect property of the Summer/After School program facilities.
f) Notify a Summer/After School program program staff member immediately regarding any issues.
g) Leave the building at dismissal. Wait quietly in the lobby if waiting for an escort.

h) Walk safely in the building and speak in an appropriate tone and volume.
i) Refrain from using electronic games and toys during the Afterschool program.
Children are asked to adhere to the following agreement.

3. AS A SUMMER/AFTER SCHOOL PROGRAM MEMBER, I PROMISE TO (to be signed by student):

a) Always treat others with respect
b) Use only polite, kind words
c) Always listen to and respect the Afterschool staff
d) Respect Recreation Center property
e) Respect other people and their property
f) Always keep my hands and feet to myself
g) Always ask permission before leaving the Afterschool area
h) Avoid fighting, bullying, and teasing others
i) Follow the Afterschool schedule
j) Not chew gum or eat candy
k) Always resist peer pressure
l) Take responsibilities for my actions
m) Always stand up for my beliefs
n) Always resolve conflict nonviolently
o) Respect other people's cultural/racial/ethnic background
p) Always help others when they are in need of help
q) Always tell the truth
r) Always clean up after myself
s) Be proud of who I am

Child Signature: _____ Date: _____

I acknoweledge and understand all of the above statements in this document

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

BumbleBeesRus
Summer/After School Program
76 Lorraine Street
Brooklyn, NY 11231
Email: **(718) 858-8511**
BumbleBeesRus.com

Dear Parents,

Thank you for choosing BumbleBeesRus. We are proud to be your family's Summer/ After School Program partner.

A large part of our program will revolve around the health and safety of your child, and in order to protect all our children, we ask that you submit the following documents prior to entry date.

1) **COMPLETED PHYSICAL EXAM**
Please see the forms and information included in the enrollment packet, which provide details regarding specific medical and immunization requirements.

2) **COMPLETED CHILD HEALTH HISTORY FORM**

3) **COMPLETED FOOD ALLERGY PLAN**
To ensure the health and safety of your child, please fill out the Food Allergy Plan, even if your child does not have allergies. If your child has allergies, please have your child's physician fill out the form in detail so that we know about each allergy that your child has, including any allergy medication to be administered.

4) **COMPLETED ASTHMA ACTION PLAN**
If your child has asthma, your physician is required to fill out and sign out this form.

5) **COMPLETED MEDICATION ADMINISTRATION CONSENT FORM**
If your child has medication that must be administered, please fill this out with your physician.

6) **HEALTH SCREENINGS CONSENT AND SICK POLICY FORM**

Thank you and we look forward to providing a safe and fun environment for your children.

Regards,

BumbleBeesRus Summer/After School Program Administration

NYC | Department of Health and Mental Hygiene | Department of Education

SEPTEMBER 2019

MEDICAL REQUIREMENTS FOR CHILD CARE AND NEW SCHOOL ENTRANTS

(PUBLIC, PRIVATE, PAROCHIAL SCHOOLS AND CHILD CARE CENTERS)

ALL STUDENTS ENTERING A NEW YORK CITY (NYC) SCHOOL OR CHILD CARE FOR THE FIRST TIME MUST HAVE A COMPLETE PHYSICAL EXAMINATION AND ALL REQUIRED IMMUNIZATIONS

The comprehensive medical examination must be documented on a Child Adolescent Health Examination Form (CH205) and include the following:

Weight	Body Mass Index	Medical History
Height	Vision Screening	Developmental Assessment
Blood Pressure	Hearing Screening	Nutritional Evaluation
	Dental Screening	

All students entering NYC public or private schools or child care (including Universal 3-K and Pre-Kindergarten classes) for the first time must submit a report of a physical examination performed within one year of school entry. Because children develop and grow so quickly at these early ages, if this initial examination is performed before the student is age 5 years, a second examination, performed between the child's fifth and sixth birthday, is also required. Fillable CH-205 forms that include the student's pre-populated vaccination histories are available in the NYC Citywide Immunization Registry (CIR). A savable version of the pre-populated CH-205 is also available in the CIR and is accessible for use and updates as needed.

Required Screening for Child Care Only	
Screening	**Required Information**
Anemia Screening	Hematocrit and Hemoglobin
Lead Screening, Assessment and Testing	• All children under age 6 years must be assessed annually for lead exposure. • Blood lead tests are required for children at ages 1 and 2 years AND other children up to age 6 years if they are at risk of exposure OR if no lead test was previously documented. • For more information, call the Lead Poisoning Prevention Program at 311, or visit https://www1.nyc.gov/assets/doh/downloads/pdf/lead/lead-guidelines-children.pdf

IMMUNIZATION REQUIREMENTS 2019–20

The following immunization requirements are mandated by law for all students between the ages of 2 months and 18 years. Children must be excluded from school if they do not meet these requirements. To be considered fully immunized, a child must have an immunization history that includes all of the following vaccines. The child's immunization record should be evaluated according to the grade they are attending this school year.

PROVISIONAL REQUIREMENTS

New students may enter school or child care provisionally with documentation of at least this initial series of immunizations. Once admitted provisionally, subsequent vaccines must be administered in accordance with the Advisory Committee on Immunization Practices (ACIP) "catch up" schedule for the child to be considered "in process" and remain in school (refer to http://www.cdc.gov/vaccines/schedules/hcp/imz/catchup.html). Alternative schedules are not acceptable. Students must complete the entire series to comply with the law. Students who have not been immunized within the provisional period must be issued exclusion letters and excluded from school or child care until they comply with the requirements.

CHILD CARE/PRE-KINDERGARTEN	NO. OF DOSES
DTaP (diphtheria-tetanus-acellular pertussis) OR DTP (diphtheria-tetanus-pertussis)	1
IPV (inactivated poliovirus) or OPV (oral poliovirus)	1
MMR (measles-mumps-rubella) On or after the first birthday.	1
Hib (*Haemophilus influenzae* type b)	1
Hepatitis B	1
Varicella On or after the first birthday.	1
Pneumococcal conjugate (PCV)	1
Influenza Depending on their influenza vaccine history, some children may need two doses of influenza vaccine. A second dose is not required.	1

KINDERGARTEN THROUGH GRADE 12	NO. OF DOSES
DTaP, DTP, DT, Td (tetanus-diphtheria) OR Tdap (tetanus-diphtheria-acellular pertussis) Vaccine type as appropriate for age.	1
Tdap (grades six through 12)	1
IPV or OPV	1
MMR On or after the first birthday	1
Hepatitis B	1
Varicella On or after the first birthday.	1
Meningococcal (MenACWY) (seventh, eighth, ninth, tenth and 12th grades)	1

2019–20: FULL COMPLIANCE

New York State Immunization Requirements for Child Care and School Entrance/Attendance[1]

Notes: For grades Pre-Kindergarten through 11, intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for people age 0 through 18 years. Intervals between doses of vaccine DO NOT need to be reviewed for grade 12. Doses received before the minimum age or intervals are not valid and do not count. You MUST reference the footnotes for dose requirements and specific information about each vaccine. Children enrolling in grade-less classes should meet immunization requirements for their age-equivalent grade.

VACCINES	PRE-KINDERGARTEN (Child Care, Head Start, Nursery, 3K or Pre-Kindergarten)	KINDERARTEN through Grade 5	GRADES 6 through 11	GRADE 12
Diphtheria and tetanus toxoid-containing vaccine and pertussis vaccine (DTaP/DTP/DT/Td/Tdap)[2]	**4 doses**	**5 doses** or **4 doses** if the fourth dose was received at age 4 years or older or **3 doses** if the child is age 7 years or older and the series was started at age 1 year or older	**3 doses**	
Tetanus and diphtheria toxoid-containing vaccine and pertussis vaccine booster (Tdap)[3]	**Not Applicable**		**1 dose**	
Polio vaccine (IPV/OPV)[1,4]	**3 doses**	**4 doses** or **3 doses** if the third dose was received at age 4 years or older	**4 doses** or **3 doses** if the third dose was received at age 4 years or older	**3 doses**
Measles, mumps and rubella vaccine (MMR)[1,5]	**1 dose**	**2 doses**		
Hepatitis B vaccine[1,6]	**3 doses**	**3 doses**	**3 doses or 2 doses of adult hepatitis B vaccine** (Recombivax HB) for children who received the doses at least 4 months apart between the ages of 11 through 15 years	
Varicella (chickenpox) vaccine[1,7]	**1 dose**	**2 doses**		**1 dose**
Meningococcal conjugate vaccine (MenACWY)[8]	**Not Applicable**		**Grades 7, 8, 9 and 10: 1 dose**	**2 doses** or **1 dose** if the first dose was received at age 16 years or older
***Haemophilus influenzae* type b conjugate vaccine (Hib)[9]**	**1 to 4 doses**	**Not Applicable**		
Pneumococcal conjugate vaccine (PCV)[10]	**1 to 4 doses**	**Not Applicable**		
Influenza[11]	**1 dose**	**Not Applicable**		

For more information contact:
New York State Department of Health, Bureau of Immunization: 518-473-4437
New York City Department of Health and Mental Hygiene, Bureau of Immunization: 347-396-2433; Office of School Health Citywide (all districts): 347-396-4720

1. Documented serologic evidence of immunity to measles, mumps, rubella, hepatitis B, varicella or polio (for all three serotypes) meets the immunization requirements for these diseases. Diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.
2. **Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine (Minimum age: 6 weeks)**
   a. Children starting the series on time should receive a five-dose series of DTaP. vaccine at ages 2, 4, 6, 15 through 18 months, and age 4 years or older. The fourth dose may be received as early as age 12 months, provided at least six months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least four months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday.
   b. If the fourth dose of DTaP was administered at age 4 years or older, the fifth (booster) dose of DTaP vaccine is not necessary.
   c. A sixth dose of DTaP, at least six months after the prior dose, may be required if the fifth dose was received prior to the fourth birthday.
   d. For children born before January 1, 2005, only immunity to diphtheria is required, and doses of DT and Td can meet this requirement.
   e. Children ages 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td vaccine. If the first dose was received before their first birthday, then four doses are required. If the first dose was received on or after the first birthday, then three doses are required
3. **Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine (Minimum age: 7 years)**
   a. Students ages 11 years or older entering grades six through 12 are required to have one dose of Tdap.
   b. Students without Tdap who are age 10 years in sixth grade are in compliance until they turn age 11 years.
   c. A dose of Tdap or DTaP administered on or after age 7 years meets this requirement.
4. **Inactivated poliovirus vaccine (IPV) or oral polio vaccine (OPV) (Minimum age: 6 weeks)**
   a. Children starting the series on time should receive IPV at ages 2, 4, 6 through 18 months and age 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least six months after the previous dose.
   b. For students who received their fourth dose before age 4 years and prior to August 7, 2010, four doses separated by at least four weeks is sufficient.
   c. If the third dose of polio vaccine was received at age 4 years or older and at least six months after the previous dose, a fourth dose of IPV is not necessary.
   d. A fifth dose of IPV, at least six months after the prior dose, may be required if the fourth dose was received prior to the fourth birthday.
   e. If both OPV and IPV were administered as part of a series, the total number of doses and intervals between doses is the same as that recommended for the. IPV schedule.
   f. Only OPV administered before April 1, 2016 counts towards the completion of the polio series.
5. **Measles, mumps and rubella (MMR) vaccine (Minimum age: 12 months)**
   a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (four weeks) after the first dose to be considered valid.
   b. Students in kindergarten through grade 12 must have received two doses of measles-containing vaccine, two doses of mumps-containing vaccine (except one dose of mumps-containing vaccine for grade 12), and at least one dose of rubella-containing vaccine.
6. **Hepatitis B vaccine (Minimum age: birth)**
   a. The first dose may be given at birth or anytime thereafter. The second dose must be received at least four weeks (28 days) after the first dose. The third dose must be given at least eight weeks after the second dose AND at least 16 weeks after dose one AND no earlier than 24 weeks of age.
   b. Two doses of adult hepatitis B vaccine (Recombivax®) received at least four months apart at age 11 through 15 years will meet the requirement.
   c. Administration of a total of four doses of hepatitis B vaccine is permitted when a combination vaccine containing Hep B is administered after the birth dose. This fourth dose is often needed to ensure that the last dose in the series is given on or after age 24 weeks.
7. **Varicella (chickenpox) vaccine (Minimum age: 12 months)**
   a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (four weeks) after the first dose to be considered valid.
   b. For children younger than age 13 years, the recommended minimum interval between doses is three months (though if the second dose was administered at least four weeks after the first dose, it can be accepted as valid); for people age 13 years and older, the minimum interval between doses is four weeks.
8. **Meningococcal Vaccine (MenACWY) (Minimum age: 6 weeks)**
   a. Students entering grades seven, eight, nine, and ten are required to have received a single dose of meningococcal conjugate vaccine against serogroups A, C, W-135 and Y (MenACWY vaccine).
   b. Students entering grade 12 will need to have received two doses of MenACWY vaccine, or only one dose of MenACWY vaccine if the first dose was administered at age 16 years or older.
   c. If the second dose was administered before age 16 years, then a third dose given on or after age 16 years is required.
   d. The minimum interval between doses of MenACWY vaccine is eight weeks.
9. ***Haemophilus influenzae* type b conjugate vaccine (Hib) (Minimum age: 6 weeks)**
   a. Children starting the series on time should receive Hib vaccine at ages 2 months, 4 months, 6 months and 12 through 15 months.
   b. If two doses of vaccine were received before age 12 months, only three doses are required, with the third dose at age 12 through 15 months and at least eight weeks after the second dose.
   c. If the first dose was received at ages 12 through 14 months, only two doses are required, with the second dose at least eight weeks after the first dose.
   d. If the first dose was received at age 15 months or older, only one dose is required.
   e. Hib vaccine is not required for children ages 5 years or older.
10. **Pneumococcal conjugate vaccine (PCV) (Minimum age: 6 weeks)**
    a. Children starting the series on time should receive PCV vaccine at ages 2 months, 4 months, 6 months and 12 through 15 months.
    b. Unvaccinated children ages 7 through 11 months are required to receive two doses, at least four weeks apart, followed by a third dose at age 12 through 15 months.
    c. Unvaccinated children ages 12 through 23 months are required to receive two doses of vaccine at least eight weeks apart.
    d. If one dose of vaccine was received at age 24 months or older, no further doses are required.
    e. For more information, refer to the PCV chart available in the School Survey Instruction Booklet at www.health.ny.gov/prevention/immunization/schools/.
11. **Influenza Vaccine (Minimum age: 6 months)**
    a. All children 6 months through 59 months of age enrolled in New York City Article 47 & 43 regulated pre-kindergarten programs (Child Care, Head Start, Nursery, or Pre-K) must receive one dose of influenza vaccine between July 1st and December 31st of each year.
    b. Depending on their prior influenza vaccination history, some children may need two doses of influenza vaccine; however, a second dose is not required for school entry. Please refer to the Centers for Disease Control and Prevention (cdc.gov/flu) or New York City Department of Health (https://www1.nyc.gov/site/doh/health/health-topics/flu-seasonal.page) website.

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? ☐ 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 ☐

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 ___/___/___

DOHMH ONLY **PRACTITIONER I.D.**

Health Care Practitioner Name and Degree *(print)*

Practitioner 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

REVIEWER:

Telephone Fax Email

FORM ID#

Child Health History Form

Child's Name _____ Date of Birth _____

Hospitalization, Accidents, Illnesses and Medication	Yes/No
Was child ever hospitalized or operated on?	
Has child ever had a serious accident?	
Has child ever had a serious illness?	
Is your child currently taking medication? Which medication?	
Comments:	

Has your child ever had or currently have any of the following concerns or does your child complain about any of the following? (Please check all that apply)

Frequent sore throat		Frequent cough		Urinary infections		Stomach pain, concerns	
Difficulty seeing		Currently wear glasses		Ears/hearing		Seizures, convulsions	
Comments:							

Has your child ever had or does your child currently have any of the following diseases? (Please check all that apply)

Asthma		Bleeding tendencies		Diabetes		Epilepsy	
German Measles		Measles		Heart/Blood Vessel Disease		Liver Disease	
RheumaticFever		Sickle Cell Disease		Boils or Hives		Chicken Pox	
Eczema		Mumps		Whooping Cough		Polio	
Comments:							

Child Health History Form continued on the next page

Allergies & Other Conditions

Any allergies to foods, medication, environment, or animals?
Does any of the above affect your child's everyday activities?
Does your child have asthma?
Are there any other conditions that may affect everyday activities that wasn't discussed above?

Pregnancy/Birth History	**Yes/No**
Did mother have any health problems during pregnancy, delivery?	
Did mother visit a physician fewer than 2 times during pregnancy?	
Was your child born outside of the hospital?	
Was your child born more than 3 weeks early or late?	
Were there any concerns with the child during or immediately after delivery?	
Was the hospital stay extended?	
Comments:	

Parent/Guardian Signature: _____ Date: _____

IF YOUR CHILD HAS ALLERGIES, THIS FORM MUST BE COMPLETED BY YOUR CHILD'S PHYSICIAN.

Food Allergy Plan

Child's Name _____ **Date of Birth** _____

☐ This child does NOT have a food allergy that requires restrictions or medications.

☐ This child does NOT have any allergies.

	Name of Allergen (pea nuts, eggs, shellfish, etc.)	**Previous reactions** (rash, lip swelling, nausea/ vomiting, difficulty breathing, anaphylaxis;etc.):	**Dietary Restriction**	**Emergency Treatment, if required ***
1			☐ Complete avoidance ☐ Avoid in these specific forms: ☐ Other recommendations: _____ _____	☐ Epinephrine ☐ Benadryl ☐ Other: _____
2			☐ Complete avoidance ☐ Avoid in these specific forms: ☐ Other recommendations: _____ _____	☐ Epinephrine ☐ Benadryl ☐ Other: _____
3			☐ Complete avoidance ☐ Avoid in these specific forms: ☐ Other recommendations: _____ _____	☐ Epinephrine ☐ Benadryl ☐ Other: _____
4			☐ Complete avoidance ☐ Avoid in these specific forms: ☐ Other recommendations: _____ _____	☐ Epinephrine ☐ Benadryl ☐ Other: _____

***If child requires medication for this allergy, please complete the Medication Consent Form for each medication required, and provide parent with prescription(s) for additional medication to be kept at the childcare program site.*

Does this child have an allergist? ☐ Yes ☐ No Name of Allergist: _____ Phone Number:(__) __ -_____

Health Care Provider (MD, DO, NP, PA): _____ Date _____

Signature

Print Name of Health Care Provider: _____ Address _____

Fax Number _____ Phone Number _____

Date received by BumbleBeesRus _____

Parent's Signature _____ Date _____

Enrollment Coordinator Signature _____ Date _____

Clear Form

Asthma Action Plan

[To be completed by Health Care Provider]

Medical Record #:	Updated *On:*

Name _____ Date of Birth _____

Address _____ Emergency Contact/Phone _____

Health Care Provider Name _____ Phone _____ Fax _____

Asthma Severity: ☐ Intermittent ☐ Mild Persistent ☐ **Moderate Persistent** ☐ **Severe Persistent**

Asthma **T**riggers: ☐Colds ☐**Exer**cise ☐Animals ☐Dust ☐Smoke ☐Food ☐**W**eather ☐**Other**

If Feeling Well (Green Zone) — Take Every Day Long –Term Control Medicines

You have all of **these:**
- Breathing is good
- No cough or wheeze
- Can work / play
- Sleeps all night

Peak flow in this **area:**
_____ to _____

MEDICINE:	HOW **MUCH:**	WHEN TO **T**AKE **IT:**

5-15 minutes before exercise use this ***medicine***

If Not Feeling Well (Yellow Zone) — Take Every Day Medicines and Add these Quick-Relief Medicines

You have ***any*** of **these:**
- Cough
- Wheeze
- Tight chest
- Coughing at night

Peak flow in this **area:**
_____ to _____

MEDICINE:	HOW **MUCH:**	WHEN TO **T**AKE **IT:**

Call doctor if these medicines are used more than two days a ***week.***

If Feeling Very Sick (Red Zone) — Take These Medicines and Get help from a Doctor NOW!

Your asthma is getting worse **fast:**
- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Can't walk or talk well
- Ribs show

Peak flow **r**eading **below:**
_____

MEDICINE:	HOW **MUCH:**	WHEN TO **T**AKE **IT:**

SEEK EMERGENCY CARE or CALL 911 NOW if: Lips are bluish, Getting worse fast, Hard to breathe, Can't talk or ***cr***y because of ***hard*** breathing or has passed ***out***

Make an appointment with your primary **care pr**ovider within two days of an ER visit or **hospitalization**

Health Care Provider Signature _____ Date _____

Patient/Guardian Signature [I have *r*ead and understood these *instructions]* _____ Date _____

NYC Health

New York City Department of Health and Mental Hygiene
Michael R. Bloomberg, *Mayor*
Thomas.R Frieden, M.D., M.P.H., *Commissioner*
nyc.gov/health

New York City Asthma Initiative
Adapted from Finger Lakes Asthma Action Plan and NHLBI
Revised 06/04

WHITE - PATIENT COPY
YELLOW - SCHOOL/DAY CARE COPY
PINK - PROVIDER COPY

THIS FORM MUST BE COMPLETED BY YOU (PARENT/GUARDIAN) AND YOUR CHILD'S PHYSICIAN.

OCFS-LDSS-7002 (11/2004)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

WRITTEN MEDICATION CONSENT FORM

- This form must be completed in a language in which the child care provider is literate.
- One form must be completed for each medication. Multiple medications cannot be listed on one consent form.

LICENSED AUTHORIZED PRESCRIBER MUST COMPLETE THIS SECTION (#1 - #18)

(*Parents may complete #1- #17 (omit #18) for over-the-counter topical ointments, sunscreen and topically applied insect repellent)*

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:
4. Name of medication (including strength):	5. Amount/dosage to be given:	6. Route of administration:

7A. Frequency to be administered: _____

OR

7B. Identify the symptoms that will necessitate administration of medication: (signs and symptoms must be observable and, when possible, measurable parameters) _____

8A. Possible side effects: ☐ See package insert for complete list of possible side effects (parent must supply)

AND/OR

8B: Additional side effects: _____

9. What action should the child care provider take if side effects are noted:

☐ Contact parent ☐ Contact prescriber at phone number provided below

☐ Other (describe): _____

10A. Special instructions: ☐ See package insert for complete list of special instructions (parent must supply)

AND/OR

10B. Additional special instructions: (Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situations when medication should not be administered.) _____

11. Reason the child is taking the medication (unless confidential by law): _____

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and require health and related services of a type or amount beyond that required by children generally?

☐ No ☐ Yes If you checked yes, complete #33-#34 on the back of this form.

13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered?

☐ No ☐ Yes If you checked yes, complete #35-#36 on the back of this form.

14. Date prescriber authorized:	15. Date to be discontinued or length of time in days to be given *(this date cannot exceed 6 months from the date authorized or this order will not be valid)*:
16. Prescriber's name (please print):	17. Prescriber's telephone number:

18. Licensed authorized prescriber's signature:

X

PARENT/GUARDIAN MUST COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? (For example, did the prescriber write 12pm?) ☐ Yes ☐ N/A ☐ No

This is a double-sided form **Updated 11-04**

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

WRITTEN MEDICATION CONSENT FORM

24. Provider/Facility name:	25. Facility ID number:	26. Facility telephone number:

27. I have verified that #1-#23 and if applicable, #33-#36 are complete. My signature indicates that all information needed to give this medication has been given to the day care program.

28. Authorized child care provider's name (please print):	29. Date received from parent:

30. Authorized child care provider's signature:
X

ONLY COMPLETE THIS SECTION (#31-#32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

31. I, parent/legal guardian, request that the medication indicated on this consent form be discontinued on _____
(date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent or Legal Guardian's Signature:
X

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #36)

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.

34. Licensed Authorized Prescriber's Signature:
X

35. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date by which you expect the pharmacy to fill the updated order.

DATE:_____

By completing this section the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

36. Licensed Authorized Prescriber's Signature:
X

Health Screenings Consent and Sick Policy Form

Child's Name: _____ DOB: _____

Parent/Guardian Name(s): _____

Health Screenings: (Please initial where indicated):
To assure the health of all students in our program, BumbleBeesRus will be conducting various screenings which will be performed either by in-house staff members.

The following screenings will be conducted:

- Daily Health Check (upon arrival)
- Temperature Check (upon arrival and as needed)

If any of the above is a concern, please advise the Summer/After School Program Director so that we can discuss and address appropriately.

Health Screenings (please initial):

_____ I give permission for BumbleBeesRus to conduct all screenings as listed above or as deemed necessary. Screenings may be done by either BumbleBeesRus staff/consultants and by certified organizations who partner with BumbleBeesRus for the health and well-being of my child.

OTC Medication (please initial):

_____ I give permission for the administration of the following non-ingestible over the counter medications, including sunscreen and insect repellent, as needed. I understand that such OTC medication will be brought to school in its original container and will be clearly labeled with my child's name.

Sick Policy (please initial where indicated):
To ensure the safety of all staff and children in the program, children who are ill with fever, vomiting or other illnesses detected by staff upon arrival will not be able to attend. Children who are absent for more than 2 days due to illness are required to deliver a doctor's note clearing them for attendance, Children who become ill during program hours will be required to be picked up by a parent, guardian or other authorized escort.

_____ I understand the BumbleBeesRus Sick Policy and agree to follow the requirements stated above to ensure the well being of my child.

I understand and agree to all of the topics listed in this form.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____