Enrollment Packet

2022-2023

BROOKLYN

SUNSET PARK
5721 6TH AVE.
Brooklyn, NY 11220
(718) 633-8828

PARK SLOPE
501 8TH ST.
Brooklyn, NY 11215
(718) 499-9800

PROSPECT HEIGHTS
823 CLASSON AVE.
Brooklyn, NY 11238
(718) 783-BEES

CLINTON HILL
1068 FULTON ST.
Brooklyn, NY 11238
1-855-5-DAYCARE

FLATBUSH
2813 FARRAGUT RD.
Brooklyn, NY 11210
(718) 434-2337
(347) 240-8305

RED HOOK
76 LORRAINE ST.
Brooklyn, NY 11231
(718) 858-8111
(718) 875-8134

SOUTH SLOPE
335 PROSPECT AVE.
Brooklyn, NY 11215
(718) 576-3919

STATEN ISLAND

PARK HILL
433 TARGEE ST.
Staten Island, NY 10304
(718) 727-2724

BumbleBeesRus.com

Enrollment Packet

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BumbleBeesRus
3611 14th Ave. Suite #530, Brooklyn, NY 11218
(718) 676-0080 • Fax (718) 759-6984
Email: **info@bumblebeesrus.com**
BumbleBeesRus.com

Welcome to BumbleBeesRus!

Dear Parents and Guardians,

First and foremost, I want to thank you for choosing BumbleBeesRus as your childcare provider. I am 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 me via email or phone 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,

Rivka Reinetz
Program Director
Email: *rivka@bumblebeesrus.com*
Phone: (718) 676-0080 Ext. 111

Requested Start Date: _____

Enrollment Application Form

Preferred Center: _____

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*

Only Applicable To Centers Offering Part Time Seats

Enrolled Days: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Parent/Guardian Information:

Parent 1/Guardian 1 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 2 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 1/Guardian 1 Signature: _____ Date: _____

Parent 2/Guardian 2 Signature: _____ Date: _____

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

☐ HRA: New case? Date application submitted: _____

Existing case? Case # _____ Recertification Date: _____

☐ ACS (Early Learn): 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 monthly 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. I agree to pay my child's monthly tuition in the amount of _____. Deposits will be accepted on a case-by-case basis. Deposits are non-refundable.

☐ ACS: 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 ACS form. I am responsible for my child's weekly co-pay fee even if my child does NOT attend for the week, or is absent for 1 or more days during the week.

☐ 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 Center Office Manager. Credit card payments will be processed by the Fiscal Office on the business last day of the month for the upcoming month's tuition.

☐ All Funding Streams: **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.

☐ All Funding Streams: **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, Professional Development Day, etc.). 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.

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 is the last day the center is open before the holiday/weekend.

☐ ACS ☐ HRA: Late payments and Non-Payments: I understand that payments made after the Monday after the previous Friday of the week are considered late and a late fee of $35 will be assessed. I am aware that if the Friday/Monday of the week falls on a weekend/holiday, the last day that tuition can be paid without a late fee is the day prior to when the center is open before the weekend/holiday.

☐ 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: _____

Fiscal Representative Signature: _____ Date: _____

Building for the Future

This day care facility participates in the Child and Adult Care Food Program (CACFP), a Federal program that provides healthy meals and snacks to children receiving day care.

Each day more than 2.6 million children participate in CACFP at day care homes and centers across the country. Providers are reimbursed for serving nutritious meals that meet USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

Meals CACFP homes and centers follow meal requirements established by USDA.

BREAKFAST	LUNCH OR SUPPER	SNACK (TWO OF THE FIVE GROUPS)
Milk Vegetable or fruit Grains/bread or meat/meat alternate	Milk Vegetable Fruit or vegetable Grains/bread Meat/meat alternate	Milk Vegetable Fruit Grains/bread Meat/meat alternate

Participating Facilities Many different homes and centers operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- **Child Care Centers:** Licensed or approved public or private nonprofit child care centers, Head Start programs, and some for-profit centers.
- **Family Day Care Homes:** Licensed or approved private homes.
- **Afterschool Care Programs:** Centers in low-income areas provide free snacks to school-age children and youth.
- **Homeless Shelters:** Emergency shelters provide food services to homeless children.

Eligibility State agencies reimburse facilities that offer non-residential day care to the following children:

- children age 12 and under,
- migrant children age 15 and younger, and
- youths through age 18 in afterschool care programs in needy areas.

Contact Information If you have questions about CACFP, please contact one of the following:

Sponsoring Organization

State Director, CACFP
NYS Department of Health
Division of Nutrition
150 Broadway Suite 650
Albany, NY 12204-2719
1-800-942-3858 (in NY only)
518-402-7400

USDA

English

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, 2022 until June 30, 2023)

HOUSEHOLD SIZE	REDUCED-PRICE MEALS		
	YEAR	MONTH	WEEK
1	25,142	2,096	484
2	33,874	2,823	652
3	42,606	3,551	820
4	51,338	4,279	988
5	60,070	5,006	1,156
6	68,802	5,734	1,324
7	77,534	6,462	1,492
8	86,266	7,189	1,659
FOR EACH ADDITIONAL FAMILY MEMBER	+8,732	+728	+168

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.

_____ **Discontinuation of Services**: At the Center Director's discretion, BumbleBeesRus has the right to ask a child to withdraw from our program.

_____ **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: _____

Center Director 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: ____________________

In accordance with the requirements of the New York City Health Code, Article 47, Section 47.57(h)(1) child care centers must obtain and maintain for every child a list of the name, relationship to child, address and contact information of every person the parent has authorized to escort a child from the child care service. The permittee shall not release any child to any individual who has not been identified by the parent(s)/guardian(s) as a person who is authorized to escort a child out of the service.

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 daily in our classrooms to capture the milestones that your child achieves. Photos are used for weekly newsletters, quarterly parents and family newsletters, social media, the BumbleBeesRus website and printed marketing materials. Please indicate your permission for consent and sign below. They may also be emailed by center directors to the parents of each classroom.

Photos: (Please mark your answer where indicated) Your child's classroom weekly newsletter (not visible to the public)	☐ *Yes*	☐ *No*
Daily photos shared with parents (not visible to the public)	☐ *Yes*	☐ *No*
BumbleBeesRus Parents and Family Newsletter (distributed to all centers, not visible to the public)	☐ *Yes*	☐ *No*
Social media and company website (visible to the public) *Facebook, Twitter, etc*	☐ *Yes*	☐ *No*
Printed Marketing Materials (visible to the public) *Flyers, brochures, magazines, advertisements, etc.*	☐ *Yes*	☐ *No*

Parent Signature : _____ Date _____

Welcome Parents and Caregivers!

We understand that finding the right day care is a difficult process. Rest assured that every child entrusted into our care will be nurtured and loved. At BumbleBeesRus, we continually strive to create a stimulating environment, where every child is encouraged to reach his or her own potential. We understand that every child is unique and has his/her own individual strengths and interests. Our educational philosophy is to teach multi-sensory approach; we learn through play and we play while we learn.

Additionally, any concern that you mght have will be addressed in a professional manner and we will always work together to find apropriate solutions.

Thank you for choosing BumbleBeesRus!

Center Contact Info – Family Worker/Office Staff: _____

Phone #: _____ **Email Address**: _____

NEW STUDENT SUPPLY LIST

Upon entry, the following items are required. Please make certain that all items are clearly labeled with your child's name so we can assure that it will be used for your child only. List is subject to change.

Infant	Toddler	Preschooler
☐ Prepared bottles ☐ Baby food ☐ Diapers/wipes/ointment (1 package of each) ☐ 1 box of tissues ☐ 1 roll of paper towels ☐ Standard crib sheet ☐ Seasonal change of clothing (pants, shirt, and socks)	☐ Diapers/wipes/ointment (1 package of each) OR potty training supplies (pull-ups/flushable wipes) ☐ 1 box of tissues ☐ 1 roll of paper towels ☐ Seasonal blanket (no pillows) ☐ Seasonal change of clothing (pants, shirt, underwear, socks)	☐ Potty training supplies (pull-ups/flushable wipes) ☐ 1 box of tissues per ☐ 1 roll of paper towels ☐ Seasonal blanket (no pillows) ☐ Seasonal change of clothing (pants, shirt, underwear, socks)

Food & Bottle Policy

As per the New York City Department of Health Bureau of Child Care:

Bottles:

• Parents are expected to provide a supply of prepared formula, ready-made formula, milk, (including breast milk) juice and water as per your child's daily liquid intake habits. Staff are not permitted to prepare or mix any liquids; staff may add water to formula powder that is already prepared in the bottle.

• All bottled liquids must be clearly labeled with the child's first and last name, the contents of each bottle, and the date of preparation.

• Bottled liquids will be refrigerated as necessary during the day and heated accordingly. Microwaves may not be used to heat bottles; bottles will be warmed using hot water only for half an hour prior to serving.

• Staff is not permitted to sanitize or clean bottles. Used and unused bottles will be returned at pick up time. Bottles may not be stored in the center overnight.

• Staff is not permitted to prepare any foods. All perishable food will be refrigerated as necessary. Microwaves will be used to warm/heat up foods. Foods must be stored in a microwavable container clearly labeled with the child's first and last name. Unused portions will be returned at pick up time. Food items may not be stored in the center overnight.

Pacifier:

• Pacifier use is discouraged while the child is awake or during activity times. Children tend to be 'curious' about pacifiers and tend to 'share' them, thereby sharing germs.

• Although there is much controversy over the use of pacifiers, please speak to your child's pediatrician about your child's personal pacifier habits.

_____ I have read, understood, and agree with the above policies (please initial).

Parent/Guardian Signature: _____ Date: _____

BumbleBeesRus
5902 14th Ave., Brooklyn, NY 11219
(718) 676-0080 • Fax (718) 759-6984
Email: **info@bumblebeesrus.com**
BumbleBeesRus.com

Dear Parents and Guardians,

First, let me thank you for choosing BumbleBeesRus. We are proud to be your family's child care provider and family partners.

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 required documents prior to entry date.

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

2)**COMPLETED DENTAL EXAM** for children ages 3-5 years.
Going to the dentist is never a fun experience for adults, and for children, it's a real hardship. However, oral health is so important and healthy baby teeth makes for healthy adult teeth and for a healthy child overall. It's also important to be pro-active. Let's get our children to the dentist for a checkup today and hopefully we won't need to take them in tomorrow for a cavity!

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.

Thank you and we look forward to building a healthy future for our children, selves, and community.

Regards,

Tahreem Shahid
Health & Safety Coordinator
Email: *tahreem@bumblebeesrus.com*

Medical Requirements Prior to Entry (by age):

In accordance with the rules and regulations set forth by the NYC Department of Health your child's medical must be submitted prior to being enrolled in BumbleBeesRus.

The following is the breakdown of medical and immunization requirements by age.

Age	On Medical	DtaP	Hep B	Hib	PCV	IPV	MMR	Varicella	Influenza July 31-Dec 31
Birth to 2 months	Well-Baby Visit Growth Assessment	N/A	1	N/A	N/A	N/A	N/A	N/A	N/A
2-3 months	Well-Baby Visit Growth Assessment	1	2	1	1	1	N/A	N/A	N/A
4-5 months	Well-Baby Visit Growth Assessment	2	2	2	2	2	N/A	N/A	N/A
6-8 months	Well-Baby Visit Growth Assessment	3	2	3	3	3	N/A	N/A	1
9-12 months	Well-Baby Visit Growth Assessment	3	3	3	3	3	N/A	N/A	1
12-15 months	Well-Baby Visit Growth Assessment *ACS Entrants:* *Lead* *HgB*	3	3	3	3	3	1	1	1
15-18 months	Well-Baby Visit Growth Assessment *ACS Entrants:* *Lead* *HgB*	4	3	3	4	3	1	1	1
18-36 months	Well-Baby Visit Growth Assessment *ACS Entrants:* *Lead* *HgB* *Blood Pressure* *Hearing* *Vision*	4	3	3	4	3	1	1	1
3-5 years	Physical Exam Growth Assessment *ACS Entrants:* *Lead* *HgB* *Blood Pressure* *Hearing* *Vision*	4	3	4	4	3	1	1	1

In some circumstances, your child may be accepted without all of the above requirements based on your physician's planned calendar of immunizations; a doctor's note is recommended. In such cases, it is the parent's responsibility to assure that all requirements are met within the deadline received. Please refer to the official NYC Department of Health and Mental Hygiene Medical Requirements for New School Entrants for more details, which is included in the BumblebeesRus Enrollment Packet. Religious exemptions for immunizations are not accepted.

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

SEPTEMBER 2022

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 3K 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 CH205 is also available in the CIR and is accessible for use to update as needed. For school year 2022-2023, the previous version of the CH205 form produced from the Online Registry will continue to be accepted by all NYC Public Schools, Center/School/Home-Based Care and After-School until it is replaced by the new version.

Required Screening for Child Care Only

Screening	Required Information
Anemia Screening	Hematocrit OR 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 2022–23

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 https://www.cdc.gov/vaccines/schedules/hcp/imz/catchup.html). If a child does not receive subsequent doses of vaccine at appropriate intervals and according to the ACIP catch-up schedule, the child is no longer in process and must be excluded from school within 14 days after the minimum interval identified by the ACIP catch-up schedule. 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.

VACCINES	CHILD CARE, HEAD START, NURSERY, 3K OR PRE-KINDERGARTEN	KINDERGARTEN through Grade 12
Diphtheria and tetanus toxoid-containing vaccine and pertussis vaccine (DTaP/DTP/DT/Td/Tdap)[2,3]	**One dose DTaP or DTP**	**Grades K-5: One dose DTaP, DTP, DT; or Td, Tdap (ages 7 years or older)** **Grades 6-12: one dose of Tdap**
Polio vaccine (IPV/OPV)[1,4]	**One dose**	**One dose**
Measles, mumps, and rubella vaccine (MMR)[1,5] On or after the first birthday	**One dose**	**One dose**
Hepatitis B (HepB) vaccine[1,6]	**One dose**	**One dose**
Varicella (chickenpox) vaccine[1,7] On or after the first birthday	**One dose**	**One dose**
Meningococcal conjugate vaccine (MenACWY)[8] Grades 7 through 12		**One dose**
***Haemophilus influenzae* type b conjugate vaccine (Hib)[9]** Through age 59 months (up until the 5th birthday)	**One dose**	
Pneumococcal conjugate vaccine (PCV)[10] Through age 59 months (up until the 5th birthday)	**One dose**	
Influenza[11] Depending on their influenza vaccine history, some children may need two doses of influenza vaccine. A second dose in not required for child care/pre-K attendance.	**One dose**	

2022–23: FULL COMPLIANCE

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

Notes: For all settings and grades (child care, head start, nursery, 3K, pre-Kindergarten through 12), intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for children aged 0 through 18 years. Doses received more than 4 calendar days before the recommended minimum age or interval are not valid and do not count. This 4-day grace period does not apply to the recommended 28-day minimum interval between doses of live virus vaccines (i.e., MMR, varicella). Refer to the footnotes for dose requirements and specific information about each vaccine. Children enrolling in gradeless classes should meet immunization requirements for their age-equivalent grade. Children who were not in full compliance before the start of the school year must complete requirements according to the ACIP-recommended catch-up schedule in order to remain in child care or school.

VACCINES	CHILD CARE, HEAD START, NURSERY, 3K OR PRE-KINDERGARTEN	KINDERGARTEN through Grade 5	GRADES 6 through 12	
Diphtheria and tetanus toxoid-containing vaccine and pertussis vaccine (DTaP/DTP)[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		
Measles, mumps, and rubella vaccine (MMR)[1,5]	**1 dose**	**2 doses**		
Hepatitis B (HepB) 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**		
Meningococcal conjugate vaccine (MenACWY)[8]	**Not Applicable**		**Grades 7, 8, 9,10 and 11: 1 dose**	**Grade 12: 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): OSH@health.nyc.gov

1. Documented serologic evidence of immunity to measles, mumps, rubella, hepatitis B, or varicella meets the requirements for these immunizations. Serologic evidence of immunity to polio is acceptable only if results are positive for all three serotypes and testing must have been done prior to September 1, 2019. Diagnosis by a physician, physician assistant or nurse practitioner that a child 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 months, 4 months, 6 months, 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 6 months have elapsed since the third dose. However, when retrospectively identified, the fourth dose need not be repeated if it was administered at least 4 months after the third dose. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the prior dose.

b. If the fourth dose was administered at age 4 years or older, the fifth (booster) dose is not necessary.

c. If the fifth dose was received prior to the fourth birthday, a sixth dose, administered at least 6 months after the prior dose, is required.

d. For children born before January 1, 2005, immunity only to diphtheria is required; any diphtheria-containing vaccine can meet the requirement (DTaP, DT, Td, or Tdap).

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, either Tdap or Td should be used. If the first dose of DTaP/DTP/DT was received before the first birthday, then four total doses are required to complete the series. If the first dose of DTaP/DTP/DT was received on or after the first birthday, then three total doses are required to complete the series. The final dose must be received on or after the fourth birthday.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine -- (Minimum age: 7 years)

a. Students ages 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.

b. Students without Tdap who are age 10 years upon entry to 6th grade are in compliance until they turn age 11 years.

c. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series (see footnote 2e).

d. In school year 2022-2023, only doses of Tdap (or DTaP) given at age 10 years or older will satisfy the Tdap requirement for grades 6, 7 and 8; however, doses of Tdap (or DTaP) given at age 7 years or older will satisfy the requirement grades 9 through 12.

e. DTaP should NOT be used on or after the 7th birthday but if inadvertently received, the Tdap requirement is satisfied by doses of DTaP (see footnote 3c).

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 months, 4 months, 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 6 months after the prior dose.

b. For students who received their fourth dose before age 4 years: if the 4th dose was prior to August 7, 2010, four doses separated by at least four weeks is sufficient.

c. If the third dose was received at age 4 years or older and at least 6 months after the prior dose, a fourth dose is not necessary.

d. 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. For OPV to count towards the completion of the polio series, the dose(s) must have been given before April 1, 2016, and be trivalent (tOPV).

5. Measles, mumps, and rubella (MMR) vaccine -- (Minimum age: 12 months)

a. The first dose of MMR vaccine must be given on or after the first birthday. The second dose must be given at least 28 days (four weeks) after the first dose to be considered valid.

b. Students in kindergarten through grade 12 must receive two doses of measles-containing vaccine, two doses of mumps-containing vaccine and at least one dose of rubella-containing vaccine.

6. Hepatitis B (HepB) vaccine -- (Minimum age: birth)

a. The first dose of HepB vaccine may be given at birth or anytime thereafter. The second dose must be given 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. Administration of a total of four doses is permitted when a combination vaccine containing HepB 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 6 months.

c. Two doses of adult HepB vaccine (Recombivax®) received at least four months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine -- (Minimum age: 12 months)

a. The first dose of varicella vaccine must be given on or after the first birthday. The second dose must be given 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 aged 13 years and older, the minimum interval between doses is four weeks.

8. Meningococcal Vaccine (MenACWY) -- (Minimum age: 2 months)

a. Students entering grades 7, 8, 9, 10 and 11 are required to receive a single dose of meningococcal conjugate vaccine against serogroups A, C, W-135 and Y (MenACWY vaccine).

b. Students entering grade 12 need to receive 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.

e. In school year 2022-2023, only doses of MenACWY given at 10 years or older satisfies the requirement for grades 7, 8 and 9; doses given before 10 years will satisfy the requirement for the first dose for grades 10 through 12.

9. *Haemophilus influenzae* type b conjugate vaccine (Hib) -- (Minimum age: 6 weeks)

a. Children starting the series on time and receiving PRP-T Hib vaccine should receive doses at ages 2 months, 4 months, 6 months and 12 through 15 months. If the formulation is PRP-OMP, only two doses are needed before age 12 through 15 months.

b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required, with the third dose at 12 through 15 months and at least 8 weeks after the second dose.

c. If the first dose was received at age 12 through 14 months, only 2 doses are required with second dose at least 8 weeks after the first dose.

d. If the first dose was received at age 15 months or older, no further doses are 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 must receive two doses, at least four weeks apart, followed by a third dose at age 12 through 15 months and at least eight weeks after the prior dose.

c. Unvaccinated children ages 12 through 23 months must receive two doses at least eight weeks apart.

d. If a dose was received at age 24 months or older, no further doses are required.

e. PCV vaccine is not required for children ages 5 years or older.

f. See PCV chart at https://www.cdc.gov/vaccines/schedules/downloads/child/job-aids/pneumococcal.pdf

11. Influenza Vaccine -- (Minimum age: 6 months)

a. All children 6 months through 59 months of age enrolled in NYC Article 47 & 43 regulated Child Care, Head Start, Nursery, or Pre-K programs must receive

b. one dose of influenza vaccine between July 1st and December 31st of each year.

c. 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 (www.nyc.gov/health/flu)

Well-Baby Visits for Children under the age of 24 months:

Children are required to be seen by a doctor and a physical exam submitted to BumbleBeesRus at the following intervals: 2, 4, 6, 9, 12, 15, 18, and 24 months. This means that during the school year, if your child ages into any of these groups (for example, turns 9 months old), your child will have to be seen by a doctor. Your Family Worker or Office Manager will be in touch with you to remind you about these requirements; however, your child's enrollment is contingent on compliance and it is the parent's responsibility to assure that the appropriate documentation is received in a timely manner.

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?
Are there any other conditions that may affect everyday activities that wasn't discussed above?
Comments:

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: _____

Health Screenings and Medication Consent Form

Child's Name: _____ DOB: _____

Parent/Guardian Name(s): _____

Health Screenings: (Please initial where indicated):
As mandated by Early Learn regulations and as is needed to assure the health and development of your child, BumbleBeesRus will be conducting various screenings which will be performed either by in-house staff members or fully certified external resources.

The following screenings are a list of screenings that BumblebeesRus may conduct:

- Audiology (hearing) Screening.
- Blood Pressure Exam
- Dental and Oral Health Screening.
- Growth Assessments, which includes height and weight testing
- Nutrition Review
- Vision Test
- Social-Emotional and Developmental Screenings
- Brigance and Educational Screenings

If any of the above is a concern, please advise your family worker immediately so that we can discuss and address appropriately.

Health Screenings (please initial):

_____ I give permission for BumbleBeesRus to conduct all health and developmental 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.

_____ If my child should need services, I authorize any involved agencies to release a copy of any necessary records, including my child's IEP, to BumbleBeesRus and to its staff members as deemed necessary. I give full permission for the teachers of my child to peruse any therapist notes and files.

OTC Medication (please initial):

_____ I give permission for the administration of the following non-ingestible over the counter medications, including sunscreen, diaper creams, 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.

I understand and agree to all of the topics listed in the Consent Form.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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*
	☐ ☐ 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

															IgG Titers	Date
DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Tdap	___/___/___	___/___/___					Hepatitis B	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		MMR	___/___/___	___/___/___					Measles	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Varicella	___/___/___	___/___/___					Mumps	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Mening ACWY	___/___/___	___/___/___					Rubella	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Hep A	___/___/___	___/___/___					Varicella	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Rotavirus	___/___/___	___/___/___					Polio 1	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Mening B	___/___/___	___/___/___					Polio 2	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Other _____	___/___/___	_____	___/___/___				Polio 3	___/___/___

ASSESSMENT ☐ **Well Child** (Z00.129) ☐ **Diagnoses/Problems** *(list)* **ICD-10 Code**

_____ _____
_____ _____
_____ _____

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions (*specify*) _____

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

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other _____

Health Care Practitioner Signature | **Date Form Completed** _____/_____/_____

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

Facility Name | **National Provider Identifier (NPI)**

Address | **City** | **State** | **Zip**

Telephone | **Fax** | **Email**

DOHMH ONLY **PRACTITIONER I.D.**

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

Comments:

Date Reviewed: _____/_____/_____ **I.D. NUMBER**

REVIEWER:

FORM ID#

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 _____

Center Director's Signature _____ Date _____

General Information

Student's Name_____

Date of Birth____/____/_____ Gender ___F ___M Ethnicity_____

Social Security # _____-_____-_____

Student's Address_____

Parent / Guardian 's Name _____

Cell / Phone # (_____) _____-_____

Relationship to Child (if not parent or guardian)_____

Emergency Contact_____

Name & Address of Current Dental Provider (if none leave blank)_____

Date of last dental exam and cleaning (if none leave blank) _____

Health History (Please check all that apply)

____Allergies ____Heart Problems ____Bleeding Problems ____HIV+ ____Asthma ____Seizures

____ Diabetes ____Recent Hospitalizations ____Sensitivity/Allergy to Latex ____Hepatitis

Other _____ List of Medications_____

None of the above ____

Please explain checked response(s)_____

Dental Insurance (Please fill out appropriate information below)

☐ Medicaid

__Straight Medicaid __Health First __United Healthcare __Amerigroup

__Affinity __Fidelis __MetroPlus

__Other _____

ID#_____

☐ Private Insurance (private insurance will be directly billed for dental services)

__Oxford __GHI __Cigna __HIP ____Child Health Plus __Empire BC/BS

____Other_____

ID#_____

☐ No Dental Insurance (According to NYS law, no child can be refused services due to lack of payment)

__I do not have dental insurance and want my child to be treated, however I am unable or unwilling to pay any out of pocket costs relating to the above services.

__I do not have dental insurance and agree to pay for services provided using a sliding fee scale.

__I would like assistance in obtaining dental insurance.

PLEASE TURN OVER AND SIGN BACK OF FORM ------->

Signature Required For Consent

Signed consent authorizes the following treatments to be rendered to the child by the First MedCare Inc SBHC-D for the duration of the child's enrollment at this school :

- **Oral Exam**
- **Oral Prophylaxis**
- **Fluoride Application**
- **Sealants**
- **Referrals for dental services not provided at SBHC-D**

I am the custodial parent/legal guardian of the above child and I authorize First Medcare Inc. and its affiliates to provide dental care which is limited to a dental exam or screening, cleaning, fluoride treatment and/or sealants. I also give consent for the above services to be done without my presence for the duration of my child's enrollment at this school. I acknowledge that a copy of the notice of privacy practices for First Medcare Inc. is available upon request. I give consent to release my child's most recent health information as provided to the school facility. By signing this consent, I am authorizing medical or dental information to be given to the child's school and/or current dental provider either because it is required by law or it is necessary to protect the health and safety of the child. My questions about the Notice of Privacy Practices have been answered. I understand that I do not have to allow release of my child's medical or dental information, and that I can change my mind at any time and revoke my authorization by writing to the SBHC-D. However, after a disclosure has been made, it can not be revoked retroactively to cover information released prior to the revocation. I authorize First MedCare Inc. to use the information provided above to obtain insurance information necessary for billing. I authorize First Medcare Inc. to bill and collect payment from any Medicaid funded insurance or third party payer that covers the services provided to the student, and shall be applied to the patient's benefits. If child has no dental insurance, a zero-based sliding fee scale will be used. Questions about our services can be answered by calling the number below.

I have read and understand the information listed above:_____

Parent/Guardian Signature

Date_____/_____/_____

First MedCare Inc. 8707 Flatlands Ave. Brooklyn, NY 11236 347-215-3008

For office use only:

		Date of service	Initials
1-	Review Medical History -	EPV _____	_____
2-	Oral cancer screening -	SPV_____	_____
3-	Missing teeth:	PV_____	_____
4-	Cavities:	EX _____	_____
5-	Existing restorations:		
6-	Condition:		
7-	Hygiene: Good Fair Poor		
8-	Rev OHI - yes no		
9-	Next Visit - recall referral for tx		

CHILD HEALTH RECORD:

FORM 5, DENTAL HEALTH

CHILD'S NAME:_____ **SEX:**_____ **BIRTHDATE:**_____

HEAD START CENTER:_____ **PHONE:**_____

ADDRESS:_____

PART I. TO BE COMPLETED BY HEAD START STAFF (COMPLETE AT INTERVIEW)

1. IS THE CHILD NOW RECEIVING: *If "yes," include length of time receiving fluoride*
   - Topical Fluoride Application? No_____ Unknown_____ Yes_____
   - Fluoridated water? No_____ Unknown_____ Yes_____
   - Fluoride Supplement diet? No_____ Unknown_____ Yes_____
   - (tablets_____, liquid_____)

2. DOES THE CHILD HAVE ANY TROUBLE WITH TEETH, GUMS, OR MOUTH THAN THE PARENT KNOWS ABOUT?

3. CHILD (___HAS, ___HAS NOT) PREVIOUSLY SEEN A DENTIST.
   Dentist's name_____ Date last visit_____

4. CHILD (___IS, ___IS NOT) UNDER A PHYSICIAN'S CARE.
   Physician's name_____

5. CHILD (___IS, ___IS NOT) RECEIVING MEDICATION.
   Type_____

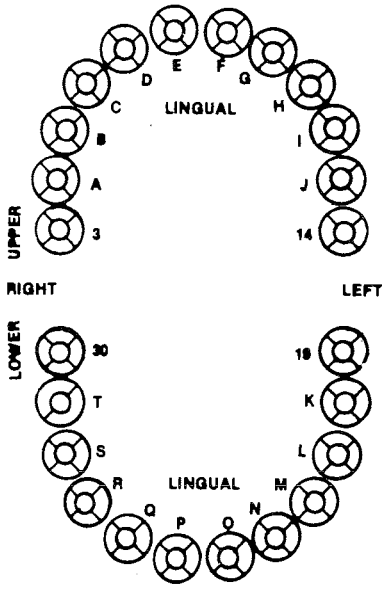
6. CHILD IS REPORTED TO HAVE *(Give details or attach Health History, Form 2A).*

	YES	NO		YES	NO
Allergies	___	___	Liver Dis.	___	___
Asthma	___	___	Rheumatic Fever	___	___
Bleeding	___	___	Sickle Cell Dis.	___	___
Diabetes	___	___	Other (List Below)	___	___
Epilepsy	___	___	_____		
Heart/Vascular Dis.	___	___	_____		

7. SOURCE OF REIMBURSEMENT OR SERVICES
   - ☐ EPSDT/Medicaid
   - ☐ Federal, State, or local Agency _____
   - ☐ Head Start
   - ☐ In-kind Provider_____
   - ☐ Parents/Guardians
   - ☐ Other (3rd Party)_____

8. PRIORITY GROUP
   - ☐ A. Needs Attention Immediately
   - ☐ B. Needs Attention Soon
   - ☐ C. Needs Routine Care

9. ORAL CONDITIONS BEFORE TREATMENT: *missing (⊗), decayed (▨), or filled (■); Indicate restorations you perform in Item 10.*



10. EXAMINATION AND TREATMENT RECORD *(List recommended services in order).*

Tooth # or Letter	Surfaces	Description of Work	Treatment Approved	Date Service Performed MO.	DAY	YR.	A.D.A. Procedure Number	Actual Charges (Fee)	

PART II. TO BE COMPLETED BY DENTAL CARE PROVIDER

11. DENTAL NEEDS *(Check one or more and return 3 copies to Head Start after first visit).*
   - ☐ A. TREATMENT (restoration, pulp therapy, extraction)
   - ☐ B. CLEANING
   - ☐ C. FLUORIDE
   - ☐ D. OTHER
   - ☐ E. NO PROBLEMS

   Approximate number of visits_____. Approximate cost_____.

12. CHILD ORAL HEALTH SUMMARY *(Complete and return 2 copies to Head Start after final visit).*
   All planned treatment (___is, ___is not) complete. If not, explain here, as well as items checked.
   _____
   _____
   - ☐ a. Routine recall visits
   - ☐ b. Special home emphasis, oral hygiene
   - ☐ c. Dietary problem(s)
   - ☐ d. Developmental problem(s)
   - ☐ e. Harmful oral habits
   - ☐ f. Needs fluoride supplement

   I certify that I have completed the service(s) listed in Part II, Item 10, and that itemized charges do not exceed my usual and customary fees.

   Signature_____ Date_____

INTERVIEWER: GO TO FORM 6

Brief Respiratory Questionnaire (BRQ)

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

1. **In the past 12 months, has your child experienced wheezing or whistling in the chest, or a cough that lasted more than a week?** ❑ Yes ❑ No

2. **In the past 12 months, how many times did your child experience wheezing or whistling in the chest, or a cough that lasted more than a week?** _____ **Number of nights** (record "0" if none)

3. **In the past 12 months, how many nights did your child have trouble sleeping because of wheezing or whistling in the chest, or a cough that lasted more than a week?**
_____ **Number of nights** (record "0" if none)

4. **I am going to read you the names of some health conditions. For each one, please tell me if a doctor, medical care provider, or clinic ever used that name to describe your child's condition.**

Asthma	❑ Yes	❑ No
RAD (Reactive Airway Disease)	❑ Yes	❑ No
Bronchitis or bronchiolitis (bron-kee-oh-lite-iss)	❑ Yes	❑ No
Asthmatic or Wheezy Bronchitis	❑ Yes	❑ No
Wheezing	❑ Yes	❑ No

5. **In the past 12 months, has a doctor, medical provider or clinic prescribed any medicine, inhaler, nebulizer, or breathing machine treatments for any of these conditions, that is for asthma, reactive airway disease, bronchitis or bronchiolitis, asthmatic or wheezy bronchitis, or wheezing?**
❑ Yes ❑ No

6. **In the past 12 months, how many times did your child have an emergency visit to a doctor, clinic or an emergency room for asthma, wheezing, cough, chest tightness, or shortness of breath?**

_____ **Number of times** (record "0" if none)

7. **In the past 12 months, how many times did your child have to stay overnight in the hospital for asthma, wheezing, cough, chest tightness, or shortness of breath?**
_____ **Number of times** (record "0" if none)

8. **Is your child currently under the care of a doctor, nurse, or clinic for asthma, wheezing, cough, chest tightness, or shortness of breath?** ❑ Yes ❑ No

9. **Does anyone in your household smoke?** ❑ Yes ❑ No

PARENT/GUARDIAN SIGNATURE _____ DATE_____

FOR CHILDREN ENROLLED IN DOE PROGRAMS

Dear Parents and Guardians,

Thank you for choosing BumbleBeesRus.

As a program, we recognize and respect that parents are our children's' primary teachers and their most important support system. We are proud to be your partner and we are dedicated to aiding and advocating for your family.

We ask that you complete the attached following required forms prior to entry date:

- Family Partnership Agreement
- Family Needs Assessment
- BBRU Parent Workshop Survey

We look forward to building a healthy future for our children, families, and community.

Sincerely,

Shari B. Klein, MsEd

BBRU Family Engagement Coordinator

Email: shari@bumblebeesrus.com

FOR CHILDREN ENROLLED IN DOE PROGRAMS

STATEMENT OF PARTNERSHIP AGREEMENT

The Family and Community Engagement staff and the parent(s) agree to work collaboratively on an ongoing basis over time to develop and implement this individualized Family Partnership Agreement. This will hopefully enhance the parent's ability to achieve their unique goals and aspirations. This document will be used to track, review and revisit goals and plans. It will be revised as needed. This IFPA may be updated as needed to better serve your family's needs.

Responsibilities agreed upon:

Bumblebees R Us:	Parent:
Staff will be on time and assure to notify you of any schedule changes as early as possible.	I will be on time and assure to notify staff of any schedule changes as soon as possible.
Staff will provide resources and support in any identified areas, including health, nutrition, mental health, child development, parenting skills, and other requested topics.	I will attend meetings and conferences regarding my child and/or family.
Staff will help you learn about and access community resources and support.	I will make sure our family participates regularly in program events and activities.
Staff will share ideas with you on how to support your child's learning at home.	Additionally I would like to participate in: ○ Encouraging my child's development and learning at home ○ Collecting and preparing materials for activities ○ Suggesting ideas for child and/or family activities ○ Serving in a parent leadership role ○ Helping at the center ○ Other: _____
Staff will regularly assess your child's development and share the progress with you.	I will contact staff with any changes in our family/home situation that might affect my child.

If you have a pre-existing Family Plan such as with a Community –Based Organization, please provide:

Organization Name: _____ Address: _____

Contact Name _____ Contact Phone Number: _____

□ I, _____ parent/guardian of _____, allow Bumblebees-R-Us to request a release of my Family Plan and retain a copy in my file. I understand that this plan will be used to build upon and expand any services or supports as needed and avoid duplication of services. Responsibility will be delegated and specified in the partnership agreement.

Parent's/Guardian signature & date. _____ _____

BBRU Administrative Staff signature & date: _____ _____

Family Partnership Agreement

Setting S.M.A.R.T. Goals with families:

***S**pecific- **M**easurable-**A**ttainable-**R**ealistic-**T**imeline **I**dentified*

Childs's Name: _____ DOB: _____ Today's Date: _____

List all members involved in the Family Partnership process:

Name and Phone Number	**Relationship to child**

1. What are the needs and/or goals/aspirations **for you**?

   _____

   _____

2. What are the needs and/or goals/aspirations **for your child**?

   _____

   _____

3. What are the needs and/or goals/aspirations **for your family?**

   _____

   _____

4. My five year plan is:

   _____

   _____

FOR CHILDREN ENROLLED IN DOE PROGRAMS

FAMILY NEEDS ASSESSMENT

Child's Name: _____ DOB: _____

Parent/Guardian Name: _____ Today's Date:_____

EMERGENCY/ CRISES ASSISTANCE

Service	Referred To: Organization Name	Follow-up
Food (Ex. Food Bank, Vouchers, etc.)		
Clothing (Ex. Clothing Banks, etc.)		
Transportation (Ex. Metro Card provided, etc.)		
Housing (ex. Emergency Shelter Placement, HPD, etc.)		
Other Specify: _____		

FOR CHILDREN ENROLLED IN DOE PROGRAMS

ADDITIONAL SERVICES:

Are you currently receiving any of the services listed below?

1. **"Preventative services?** □ **Yes** □**No**
   If you answered no, would you like a referral or information? □***R*** □***I*** □***No***

2. **"Mental Health" services?** □ **Yes** □**No**
   If you answered no, would you like a referral or information? □ ***R*** □***I*** □***No***

3. **"Domestic Violence" services?** □ **Yes** □**No**
   If you answered no, would you like a referral or information? □***R*** □***I*** □***No***

4. **"Substance Abuse" services?** □ **Yes** □**No**
   If you answered no, would you like a referral or information? □ ***R*** □***I*** □***No***

5. **"Public Assistance" services?** □ **Yes** □**No**
   If you answered no, would you like a referral or information? □ ***R*** □***I*** □***No***

6. **"Food Program" services?** □ **Yes** □**No**
   If you answered no, would you like a referral or information? □ ***R*** □***I*** □***No***

7. **"Housing" Services?** □ **Yes** □**No**
   If you answered no, would you like a referral or information? □***R*** □***I*** □***No***

8. **"Employment" Services?** □ **Yes** □**No**
   If you answered no, would you like a referral or information? □***R*** □***I*** □***No***

9. **"Job Training/Education" services?** □ **Yes** □**No**
   If you answered no, would you like a referral or information? □***R*** □***I*** □***No***

10. **"Disability" services?** □ **Yes** □**No**
    If you answered no, would like a referral or information? □***R*** □***I*** □***No***

11. **"Health Education" services?** □ **Yes** □**No**
    If you answered no, would like a referral or information? □***R*** □***I*** □***No***

12. **"Parenting Education "services?** □ **Yes** □**No**
    If you answered no, would you like a referral or information? □***R*** □***I*** □***No***

13. **"Legal" services?** □ **Yes** □**No**
    If you answered no, would you like a referral or information? □***R*** □***I*** □***No***

14. **"Substance Abuse" services?** □ **Yes** □**No**
    If you answered no, would you like a referral or information? □***R*** □***I*** □***No***

15. **Is parent on active military duty?** □ **Yes** □**No**
    Deployed? □ **Yes** □**No**
    If you answered yes, would you like a referral or information? □***R*** □***I*** □***No***

16. **Are you receiving any other services?** □ **Yes** □**No**
    If you answered yes, please specify: _____

Parent/Guardian Signature: _____ Today's Date: _____

FOR CHILDREN ENROLLED IN DOE PROGRAMS

Pre-existing Family Plans with any other organizations:

To avoid duplication of effort, or conflict with, any preexisting family and/or child plans developed between other programs and Bumblebees R Us families, the family partnership agreement must take into account, and build upon as appropriate, information obtained from the family and other community agencies concerning preexisting family plans. We must coordinate, to the extent possible, with families and other agencies to support the accomplishment of goals in the preexisting plans.

Name of Organization: _____

Address: _____

Phone Number: _____

Contact Person: _____

Reason: _____

_____

_____

Frequency of Visits: _____

□ ***I, _____ parent/guardian of _____, dob _____ , allow Bumblebeesrus to request a release of my Family Plan/IFSP/IEP and retain a copy in my file. I understand that this plan will be used to build upon and expand any services or supports as needed and avoid duplication of services. Responsibility will be delegated and specified in the partnership agreement.***

Parent/Guardian Signature: _____ Today's Date: _____

FOR CHILDREN ENROLLED IN DOE PROGRAMS

FOSTER CARE FAMILIES:

1. **Foster Parent's Name (s): _____**
2. **Foster Care Agency, name and address:**

   _____

   _____
3. **Case Worker's name and telephone number /extension: _____ _____**
4. **How long has the child been in your care? _____**
5. **Does the child have siblings? □ Yes □No**

   If yes, how many? _____ Do any/all of these siblings reside with you? _____
6. **Does the child have visitation with parents/siblings? □ Yes □No**

   If yes, how often? _____ Where? _____

   Date of last visit: _____
7. **Next Family Assessment Service Plan (FASP) due: _____**
8. **Date of next services plan review: _____**
9. **Would you like Bumblebees' staff to participate in the service plan review? □Yes □No**

   If yes, please provide the location of the service plan review: _____
10. **How can Bumblebees provide assistance /support? _____**

IMMIGRANT FAMILIES

1. **What country is your family from? _____**
2. **What is the primary language spoken in the home? _____**
3. **Are there any immigration issues or challenges that you or your family is facing? □Yes □No**

   If yes, please explain: _____
4. **How can Bumblebees provide some assistance /support?**

   _____

Skills/Training

Are you currently employed? □ YES □NO
If unemployed, are you interested in help with job training? □ YES □NO
Are you interested in help with job placement? □ YES □NO
Highest level of education completed? Parent/ Guardian _____
□GED
□ESL
□Vocational Training Program: _____
□ College Credits Completed: _____
□2- year degree program □4-year degree program □Other: _____
Are you interested in help with furthering your education? □ YES □NO

FOR CHILDREN ENROLLED IN DOE PROGRAMS

FAMILY MEDICAL HISTORY:

Name of Child _____ Current Allergies/Illness (es)_____

Treatment/Medication in Use _____

1. **Does the child have a medical home?** **□YES □NO**
   If answered no, would the family like a referral? **□YES □NO**

2. **Does the child have health insurance?** **□YES □NO**
   If answered no, would the family like a referral? **□YES □NO**

3. **Do all family members have a medical home?** **□YES □NO**
   If answered no, would the family like a referral? **□YES □NO**

4. **Do all family members have health insurance?** **□YES □NO**
   If answered no, would the family like a referral? **□YES □NO**

5. **What type of health insurance do you and your family members have?**

   Children: _____

   Parents: _____

6. **What type of medical home does your family utilize?**
   □Private Doctor □Clinic □Emergency Room □No Medical Home

7. **What is your level of satisfaction with your medical home?**

   □Satisfied □Somewhat Satisfied □Dissatisfied □No Opinion

Family referred to: _____

Follow-up: _____

_____ _____

Parent's Signature **Today's Date**

FOR CHILDREN ENROLLED IN DOE PROGRAMS

Parent Workshop Topic Survey

Please indicate your top 4 choices for upcoming Parent Workshops.

Topic	
1.Breastfeeding	
2.Pre-Natal Care	
3.Developmental Milestones	
4.Parenting Skills	
5.Behavior Management	
6.School Readiness	
7.Stress Management	
8.Safety in the Home	
9.Financial Stability	
10. Adult Education	
11.Career Help	
12. Picky Eaters	
13.Family Nutrition	
14.Childhood Obesity	
Other:	

Child's Name: _____

Parent's Signature: _____ Today's Date: _____