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
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis (latent infection or disease)
☐ Hospitalization
☐ Surgery
☐ Other (specify) _____

Explain all checked items above. ☐ ***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
Psychosocial Development	☐	☐
Language	☐	☐
Behavioral	☐	☐
HEENT	☐	☐
Dental	☐	☐
Neck	☐	☐
Lymph nodes	☐	☐
Lungs	☐	☐
Cardiovascular	☐	☐
Abdomen	☐	☐
Genitourinary	☐	☐
Extremities	☐	☐
Skin	☐	☐
Neurological	☐	☐
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	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Tdap	___/___/___	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	MMR	___/___/___	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Varicella	___/___/___	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Mening ACWY	___/___/___	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Hep A	___/___/___	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Rotavirus	___/___/___	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Mening B	___/___/___	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	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

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone | Fax | Email

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

Comments:

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

REVIEWER:

FORM ID#

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ARTScape 2019 Student Medical Form

Student: _____ **Home Phone:** (_____) _____
Last Name First Name Middle Initial

Birth Date: _____ **Age:**_____ **Sex:** ☐ **M** ☐ **F** ☐ **Transgender** ☐ **Gender Non-Conforming**

Grade Entering: _____ **Address:** _____
Street City State Zip Code

MEDICAL EMERGENCY RELEASE

In the case of a medical emergency, the School will make every effort to contact you as soon as possible.

Parent #1 _____ **Parent #2** _____ **Emergency Contact** _____

Cell# _____ **Cell#** _____ **Home#** _____

Work# _____ **Work#**_____ **Work #** _____

In case we cannot reach you, we need your consent to allow the staff to secure the necessary health care in an emergency.

Please read the following disclaimer and sign below.

By signing below, the above named student (and parent(s) or guardian also signing below if the student is under 18 years of age), represent to The Harlem School of Arts that each of the person signing below understands the risks of injury that are described below, and agrees that the above named student assumes all risks associated with participation in activities offered by the School, including without limitation, dance classes, theater classes, music classes or visual arts classes, workshops or activities within. By signing below, the above-named student (and parent(s) or guardians also signing below if the student is under 18 years of age), further agree to hold harmless the School, its agents, Directors, officers and employees all as set forth below.

I am aware that participation in the Classes can be dangerous activity involving MANY RISKS OF INJURY. I hereby voluntarily assume all risks associated with participation and agree to hold harmless the School, its directors, officers, employees, and agents for all liability, claims, causes of action or demands of any kind and nature whatsoever which may arise by or in conjunction with my participation in any activities related to the Classes, including, but not limited to, any medical care given to me and the transportation connected therewith, except for gross negligence. The terms of this agreement shall serve as a release and assumption of risk for me, my parent (s) or legal guardian who has signed below, heirs, estate, executor, administrators, assignees and all members of my family.

To the best of the knowledge of each person signing below, the student named above is in good health and suffers no disability or condition which renders his or her participation in the classes or other activity inadvisable, or otherwise limits his or her ability to participate in such activity dance or theater activity or other activities without restriction.

I hereby authorize all representatives of the School to obtain in my behalf first aid, medical care, or if necessary admission to an appropriate health care facility, including, but not limited to, anesthesia and surgery, should such care become necessary for the treatment of any injuries I may sustain while attending the School. I also hereby consent to the administration of emergency medical treatment in the event I am unable subsequent to such injury; to give consent as otherwise would be necessary.

Any qualified medical personnel are hereby notified that this authorization is currently in effect as such personnel are directed to act upon such authorization without delay. I understand that reasonable efforts will be made to contact parents, the student's physician and/or emergency numbers given by me on this form.

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

HEALTH INSURANCE INFORMATION

Name of Insurance Carrier: **Telephone Number:**

Address:

Name of Subscriber:

Type of Policy: **Policy Number:** **ID Number:**

PLEASE ATTACH COPIES OF YOUR HEALTH INSURANCE AND PRESCRIPTION PLAN (if any) CARDS TO THIS FORM
If you belong to an HMO and would like your child referred to a specific primary care physician or specialist, please indicate in writing.

HEALTH HISTORY

Allergies (including environmental):

Chronic Illnesses:

Medications:

MEDICATION RELEASE

I give permission to The Harlem School of Arts staff to administer the following medication in age-appropriate doses to my child on an as-needed basis:

	Yes	No
Tylenol/Ibuprofen:	_____	_____
Decongestants	_____	_____
Antihistamines	_____	_____
Antacids	_____	_____

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

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ARTScape 2019 Parent Agreement

- Half Day Campers **will not** participate in field trips, recreational activities, and additional activities in the afternoon.

- Parents are also responsible for submitting a signed copy of the **Student Medical Form** and complete all other registration documents (conduct & discipline, swimming permission slip, photo/video consent, emergency contact and trip itinerary) **due no later than Friday, June 21, 2019.**

- Parents must pay in **FULL** no later than **June 21, 2019** to begin session(s) in ARTScape 2019. Unpaid balances as of **June 21, 2019** will result in camper not participating in ARTScape 2019 Summer Day Camp. Any registration form accepted after **June 21, 2019** will pay a **FULL** one-time payment of tuition fees.

- Once a camper has registered, the payer of the camper's account is responsible for **FULL** payment of tuition for which the camper is enrolled. Parents/guardians wishing to withdraw a camper from camp must do so 4 weeks prior to the first day of the session by the following method:

  Submit a withdrawal or cancellation request via email to info@hsanyc.org

- Parents/guardians wishing to withdraw and camper from camp after July 8, 2019 must do so within the first 2 days of camp by the following method:

  Submit a withdrawal or cancellation request via email to info@hsanyc.org

Refund requests made within one month prior to **July 8, 2019**, will result in a **FULL** refund.
Refund requests made after **July 8, 2019**, will result in **no refund** and a $100 administration fee will apply.

- For an additional fee of $110.00 per (2) week session, Early Drop begins at 7:45am. $165.00 per (2) week session, Late Pick-Up ending at 5:30pm. **Note: Any camper picked up after 6:30pm will be charged $10.00 late fee to the payer of the camper's account. This charge will be applied daily. If a camper is not picked-up by 6:45pm and we have not received any communication from parent/guardian, camper will be escorted to nearest police precinct (AS PER ACS PARENT GUIDE HANDBOOK).**

I have read, understand and agree with the terms as stated in this document.

Parent/Guardian Signature: _____

Name of child attending Summer Camp _____

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ARTScape 2019 Summer Day Camp Conduct Policy Form

The Harlem School of the Arts, ARTScape 2019 Summer Day Camp Program provides a fun, supportive and safe environment for children to learn and develop. It is our responsibility to ensure the safety of all children. HSA's summer camp staff will make every effort to help children understand the difference between the importance of acceptable and unacceptable behavior.

Behavior Expectations

- Children must cooperate with staff and follow directions at all times
- Children must respect other children, staff, HSA equipment and facilities
- Children must stay with their designated group or counselor(s)
- Children must refrain from any behavior that threatens the safety or well-being of any child or staff person in our program, including themselves

Threatening behaviors that are unacceptable include, but not limited to:

- Making fun of, insulting, or bullying someone
- Making obscene gestures or comments
- Punching, kicking, slapping, biting, or using physical violence of any kind
- Using foul langue and profanity
- Taking someone's belonging without permission or stealing
- Writing inappropriate things about someone other campers, staff etc.
- Gossiping about someone
- Threatening someone with verbal/physical violence

ARTScape 2019 Summer Day Camp Conduct Policy & Process

First Offense: A verbal warning by the instructor and notification to the parent or guardian
Second Offense: Any child unable to comply with the behavior expectations, the site Coordinator and/or Director will set up an in-person conference with the parent/guardian
Third Offense: If the child continues to be disruptive and/or unsafe, the child will be subject to suspension or dismissal.

Failure of the parent/guardian to attend conferences and cooperate with Camp Policies, will subject the child to suspension or permanent dismissal from the program.

The use of corporal punishment is not allowed in HSA's ARTScape 2019 Summer Day Camp program. Corporal punishment is the use of physical force to the body as a discipline measure. Physical force of the body included but is not limited to spanking, slapping, biting and shaking.

To view the complete HSA Student Conduct Policy Handbook please visit **www.HSAnyc.org**

I have read, understand and agree with the policies as stated in this document and discussed the expectations of behavior with my child.

Parent/Guardian Signature: _____

Name of child attending Summer Camp _____
(Please Print)

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ARTScape 2019 Summer Day Camp 2019 Consent Agreement Form

SWIMMING

I give permission for my child to participate in recreational swimming activities. I understand that the pool at Riverbank State Park is 4 feet across and for safety reasons, **campers in red groups (ages 4-5)** and **children under 4 feet 5 inches tall will not be allowed to swim in the pool regardless of swimming abilities**. Campers will instead utilize the sprinkler/park area.

Please check one:

☐ My child is a swimmer. (My child can swim in 4 or more feet of water without assistance).

☐ My child is a non-swimmer.

***All swimmers and non-swimmers will be tested their first week to assess their swim level (shallow/deep) prior to participating in any recreational swim activities.**

PHOTO & VIDEO RELEASE

I agree to give The Harlem School of the Arts (HSA) the right and permission to use my child and/or my child's name, picture (photograph, video or illustration), written or spoken words for reproduction in any publication or media prepared by HSA.

I waived any right to inspect or approve the finished materials that include my child and /or my child's name, picture and/or written or spoken words. I knowingly and voluntarily agree to hold harmless the Harlem School of Arts regarding the reproduction, publication, or other use of the Student's Likeness and Work, and further acknowledge and agree that by signing this Agreement, I waive any claim or cause of action I otherwise might have against the School regarding such usage or damage resulting therefrom.

I have read and full understand the above information and agree to its contents.

_____

Parent/Guardian Signature:

_____

Date: