Queens Community House

Strengthening neighborhoods. Inspiring change.

Queens Community House Registration Form
PS 499 Program
148-20 Reeves Ave Flushing, NY 11367

OSIS #: ________________ **Date Received:** ______

Participant Information

1. Last Name
2. First Name
3. Middle
4. Gender
5. Birth Date (Month / Day / Year)
6. Race/Ethnicity ☐ 1. American Indian ☐ 2. Asian ☐ 3. Black ☐ 4. Hispanic/Latino ☐ 5. Pacific Islander ☐ 6. White ☐ 7. Middle Eastern ☐ 8. Other

6 A. T-Shirt Size (circle one) S(6-7) M(8-10) L(12-14) XL(16-18)

7. Home Phone Number (Area code) - -
8. Cell (Area code) - -
9. Email Address:
10. Street Address (number and street)
11. Apt #
12. City
13. State
14. Zip Code
15. Borough Code 1. Bronx 2. Brooklyn 3. Manhattan 4. Queens 5. Staten Island
16. School Type: ☐ 1. Public ☐ 2. Private ☐ 3. YABC ☐ 4. Charter ☐ 5. College ☐ 6. GED ☐ 7. Adult Learning Center ☐ 8. Vocational Training
17. School Attending: ________________
18. Grade:

19. Country of Origin: ________________
20. Primary Language
21. Secondary Language
22. Department: Y O U T H
23. Primary QCH Program: P S 4 9 9 Family Sustained
24. Other QCH Program

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Parent/Guardian / Other Information

25. Last Name ______ FirstName ______

27. Street Address (number and street) if different ______ **28.** Apt # ______

29. City ______ **30.** State ______ **31.** Zip Code ______

32. Borough Code ☐ 1. Bronx 2. Brooklyn 3. Manhattan 4. Queens 5. Staten Island

33. Email Address: ______

34. Home Phone Number: (Area code) ___ - ___ - ___ **35.** Work Phone (Area code) ___ - ___ - ___

36. Cell Number: ___ - ___ - ___

37. Primary Language: ______

38. Secondary Language: ______

Emergency Contact Name ______________________ **Emergency Contact #** ______________________

Additional Information Needed

In addition to yourself, please list names of individuals authorized to pick up your child from the program. Your child will not be permitted to leave with anyone unless his or her name is listed below. Everyone, including you, will be asked to show valid photo identification upon pick up. We must be notified in advance of any additional individuals you authorize to pick up your child from the program.

AUTHORIZED TO PICK UP (First & Last Name)	RELATIONSHIP	PHONE NUMBER

AN AUTHORIZED PICK UP PERSON OR I WILL PICK UP MY CHILD AT DISMISSAL: YES / NO

MY CHILD CAN GO HOME BY HIM/HERSELF AT DISMISSAL (**ALL** ***CHILDREN IN THE 1st, 2nd, 3rd and 4th GRADES MUST BE PICKED UP***) **YES / NO** (Circle one) INITIAL ______________

My child **MAY NOT** go home with ______________________ Relationship to Child: ______________

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Photo/Video Release Consent

Please indicate if we have permission to use photographs or video of your child or ward in Queens Community House promotional materials (e.g., brochures, newsletter, website, Instagram, Facebook).

____ Yes ____ No X______________________________ ______________

Parent /Guardian Signature Date

Medical Consent

I give consent for program staff to obtain necessary emergency medical treatment for my child with the understanding that that a parent/guardian will be notified as soon as possible.

X__________________________ X______________________________ ______________

Participant Name **Parent/Guardian Signature** **Date**

Survey Parent Permission Form

In order to assure that Queens Community House- Youth Services is of high quality and has a positive impact on your child(ren), Queens Community House engages in ongoing evaluation and quality improvement efforts. Therefore, your child (3rd grade and above) will be asked to fill out surveys. All data obtained from your child will be kept confidential and used by the program to increase the quality of the program. Participation is completely voluntary. You have the right to terminate your child's participation at any time or refuse to participate entirely without jeopardy to your status in the program. I have read and understand this consent form and I agree to allow my child(ren) to participate in ongoing evaluation of the program by filling out surveys, participate in focus groups or filling out parent surveys, within this program toward better assessment and quality of the program.

Parent/Guardian Signature ____ Date ______________

Parent/Guardian Name Printed ____

Child First, Middle, & Last Name Printed ____

I, THE UNDERSIGNED, CERTIFY THAT ALL INFORMATION ON THIS FORM IS TRUE AND ACCURATE. I AGREE AND ACCEPT THAT I WILL ABIDE BY ALL APPLICABLE RULES AND POLICIES OF THIS PROGRAM. I CONSENT FOR MY CHILD TO BE REGISTERED TO THIS PROGRAM AND PARTICIPANT IN ALL ITS ACTIVITES.

X__________________________ X______________________________ ______________

Participant Name **Participant Signature** **Date**

X__________________________ X______________________________ ______________

Parent/Guardian Name **Parent/Guardian Signature** **Date**

HEALTH RECORD

Name: ______________________ Date of Birth: ____________

Medical History

CONDITION	YES	NO
Asthma	☐	☐
Convulsions/Seizures	☐	☐
Diabetes	☐	☐
Ear Infections	☐	☐
Chicken Pox	☐	☐
Measles	☐	☐
German Measles	☐	☐
Rheumatic Fever	☐	☐
Mumps	☐	☐
Corrective Device (glasses, hearing aid, etc.)	☐	☐
Does your child use an inhaler?	☐	☐

ALLERGY	YES	NO
Penicillin	☐	☐
Insect Stings	☐	☐
Foods	☐	☐
Plants	☐	☐
Hay Fever	☐	☐
Topical ointments	☐	☐
Other	☐	☐
If "yes" to any of the above, please specify allergy and describe reaction.		

Special Health Care Needs
Does your child have any health care needs that program staff should be aware of? ☐ YES ☐ NO If yes, please describe below

Medication
Does your child take medication for any condition or illness? ☐ YES ☐ NO If yes, please describe below.

Physician's Information	
Physician's Name:	Phone #:
Address:	

Emergency Contact: ______________ Phone Number: ______________

Relationship to child: ______________________________

Permission to Provide Treatment in Case of Emergency

I give permission to the program staff to obtain necessary emergency medical treatment for my child which includes but not limited to first aid treatment, brought to the nurse and or emergency room at the hospital, I understand that every effort will be made to contact family as soon as possible. Program staff will contact you immediately before and after medical treatment is provided for the child.

____

Parent/Guardian Signature (Required) **Date**

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Youth Services Program Policies 2019-2020

The Queens Community House asks that all participants, ages 5-21, adhere to the following policies regarding participating in any of our programs and being part of our community.

We expect participants to:

- Respect each other
- Engage in activities that foster growth, creativity, and individual strengths
- Form positive social connections
- Engage in leadership opportunities
- Develop healthy relationships with staff and seek guidance and support when needed
- Become meaningful contributors to their community
- Ensure the safety of each other, staff and community by reporting any suspicious or harmful behaviors to staff

The following are prohibited in or around Queens Community House and cause for indefinite suspension:

- Stealing
- Use of or under the influence of alcoholic beverages, drugs, or tobacco
- Use of or in possession of Vaping, E-Cigarettes, Juling
- Physical fighting
- Bullying and cyberbullying
- Gang affiliation and gang signs
- Gang accessories such as beads and colors
- Destroying or tampering with QCH property
- Racist, sexist, homophobic or otherwise derogatory language
- Violence of any kind
- No weapons of any kind

Membership in the Youth Services Programs can be denied or revoked at the staff's discretion if it is deemed that they may represent a danger to themselves or others. Parents/guardians will be notified of any infraction.

Queens Community House prohibits discrimination in all its programs and activities on the basis of race, color, national origin, sex, religion, age, disability, political beliefs, sexual orientation, or marital or family status

I agree and accept that I will abide by all applicable rules and policies of this program. I consent for my child to be registered to this program and will make sure he/she/they will follow all rules and policies.

X____________________________ X____________________________ __________
Participant Name **Participant Signature** **Date**

X____________________________ X____________________________ __________
Parent/Guardian Name **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 ____

Health insurance (including Medicaid)? ☐ Yes ☐ No | ☐ **Parent/Guardian** ☐ **Foster Parent** | **Last Name** | **First Name** | **Email** | Cell ____ Work ____

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: ______ weeks gestation

☐ Complicated by ____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* ____

☐ Foods *(list)* ____

☐ Other *(list)* ____

Attach MAF if in-school medications needed

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

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

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability
Explain all checked items above.

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) ____
☐ ***Addendum attached.***

Medications ***(attach MAF if in-school medication needed)***
☐ None ☐ Yes *(list below)*

PHYSICAL EXAM **Date of Exam:** ___/___/___

Height	______ **cm**	(____ %ile)
Weight	______ **kg**	(____ %ile)
BMI	______ **kg/m²**	(____ %ile)
Head Circumference *(age ≤2 yrs)*	______ **cm**	(____ %ile)
Blood Pressure *(age ≥3 yrs)*	____ / ____	

General Appearance:

☐ Physical Exam WNL

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

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

Validated Screening Tool Used? ☐ Yes ☐ No — Date Screened ___/___/___

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: ____

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< 1 year ☐ Breastfed ☐ Formula ☐ Both

≥ 1 year ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes *(list below)*

SCREENING TESTS	*Date Done*	*Results*
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	___/___/___ ___/___/___	____ µg/dL ____ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	___/___/___	☐ At risk *(do BLL)* ☐ Not at risk
— **Child Care Only** —		
Hemoglobin or Hematocrit	___/___/___	____ g/dL ____ %

Hearing	*Date Done*	*Results*
< 4 years: gross hearing	___/___/___	☐ *Nl* ☐ *Abnl* ☐ *Referred*
OAE	___/___/___	☐ *Nl* ☐ *Abnl* ☐ *Referred*
≥ 4 yrs: pure tone audiometry	___/___/___	☐ *Nl* ☐ *Abnl* ☐ *Referred*

Vision	*Date Done*	*Results*
<3 years: Vision appears:	___/___/___	☐ *Nl* ☐ *Abnl*
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right ____/____ Left ____/____ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental	
Visible Tooth Decay	☐ Yes ☐ No
Urgent need for dental referral *(pain, swelling, infection)*	☐ Yes ☐ No
Dental Visit within the past 12 months	☐ Yes ☐ No

CIR Number ☐☐☐☐☐☐☐☐☐☐ | Physician Confirmed History of Varicella Infection ☐ | Report only positive immunity:

IMMUNIZATIONS – DATES

										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 ___/___/___ | **DOHMH ONLY** **PRACTITIONER I.D.**

Health Care Practitioner Name and Degree *(print)* | Practitioner License No. and State | **TYPE OF EXAM:** ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip | Date Reviewed: ___/___/___ **I.D. NUMBER**

REVIEWER:

Telephone | Fax | Email | **FORM ID#**