Imagine Early Learning Centers
Enrollment Information

Name of Child Enrollment Date

Address

Age Date of Birth Gender

☐ Parent (1) Name Occupation

☐ Parent (1) Home Address ☐ Phone

☐ Parent (1) Business Address ☐ Phone

☐ Parent (1) E-mail*

☐ Parent (2) Name Occupation

☐ Parent (2) Home Address ☐ Phone

☐ Parent (2) Business Address ☐ Phone

☐ Parent (2) E-mail

Please check items in boxes provided you would like to contribute to a Center Family Directory.
Providing your e-mail address indicates you agree to receive center correspondence via e-mail.

If applicable, sibling names and ages

Describe your child's relationship with his/her siblings

What is your current child care arrangement?

Why did you decide to enroll your child at Imagine?

Does your child have any allergies or health issues we should be aware of? (i.e. asthma, sight, hearing, speech)

Things you'd like us to know about your child (i.e. personality, eating/ sleeping patterns, likes and dislikes)

Imagine Early Learning Centers
Emergency Contact Information

Child's Name DOB:

Home Address:

Parent /Guardian Name:

Phones (H): (W): (C):

Email:

Parent /Guardian Name:

Phones (H): (W): (C):

Email:

Pediatrician's name: Phone:

Allergies (if applicable):

AUTHORIZED ESCORTS:	Relationship to child	Best Contact #:
	Parent	
	Parent	
1.		
2.		
3.		

Parent Signature(s) **Date**

IT IS THE PARENT'S RESPONSIBILITY TO PROVIDE THE CENTER WITH CURRENT CONTACT INFORMATION AT ALL TIMES.

Imagine Early Learning Centers
Authorization Form

Child's Name: Center:

Parent (1): Parent (2):

Address:

Medical Authorization

I authorize the Imagine Early Learning Center staff to seek whatever emergency medical assistance is deemed necessary for the protection of my child while he/she is in their care. I understand that this authorization may include transporting my child to an emergency room, possibly via ambulance. Every effort will be made to reach the parent(s) in the case of emergency.

Pediatrician's Name Phone #

Parent Signature Date

Allergy Authorization (Please check boxes in agreement)

☐ I understand confirmation of allergies is required on my child's medical form.
☐ If my child has allergies, I realize it must be posted in the classroom(s).
☐ If I am providing an Epi-Pen for my child, I give consent for any Imagine staff member to administer the dose to my child in the case of allergic reaction.

Parent Signature Date

Please include any special instructions regarding allergies on the back of this paper.

Trip Authorization

I give permission for my child to take part in all extra-curricular activities, and to go on field trips, excursions, walks in the neighborhood, and to the Center playground. If I object to my child taking part in a specific activity or trip, I will notify the center Director. I understand that my decision not to send my child on a scheduled field trip or activity may result in my need to arrange for alternative child care for the duration of the trip/activity.

Parent Signature Date

Media Authorization

Imagine uses photographs and videos of center children for educational and promotional purposes in a safe, secure and thoughtful manner.

I give permission for photographs and/or videos that include my child, and copies of my child's artwork, to be used by the Center for any purpose that the Center may deem appropriate, including without limitation educational uses and promotion of the Center and its programs and activities, in perpetuity, in the Center's publications as well as in all other media, whether now known or later developed (e.g., the Center's website and Facebook page).

Parent Signature Date

Imagine Early Learning Centers
Permission to Apply Cream, Ointment or Sun block

Dear Imagine Parents,

Licensing regulations require permission for the staff at Imagine to apply cream, ointment or sun block to your child while here at school. This includes diaper cream, sun block and any other types of ointments. Please be specific when filling out the permission slip. **This form must be updated every 6 months.**

Thank you.

PERMISSION TO APPLY CREAM, OINTMENT or SUN BLOCK

I allow the staff members of IMAGINE Early Learning Center to apply cream, ointment or sun block to my child. I understand that I must provide these lotions and that the staff at IMAGINE is not responsible for any rash or adverse effect that might occur as a result of the application of the lotion. In addition, I understand that I am specifically responsible for applying sun block in the morning at home and the staff at IMAGINE is only responsible for reapplying in the afternoon.

Name of Child

Type of Sun block / Special Instructions:

Type of Cream / Special Instructions:

Type of Ointment / Special Instructions:

Parent Signature **Date**

Imagine Early Learning Centers
Child's Health Insurance Notification/Authorization

- Insurance carrier
- Policy number
- Name of insured

You can either fill the information in on this form and submit it or ask us to make a copy of your insurance card for your child's file.

AUTHORIZATION

I hereby authorize all Imagine staff and the following individuals to have access to my child's health information in their Imagine file (i.e. Authorized Escorts, Medical Form, and Pediatrician).

Name

Name

Name

Name

Dr:

☐ I have provided the requested health insurance information for my child(ren).

☐ I can verify health insurance coverage for my child(ren) and can readily provide it if necessary, but I *prefer not* to have that information in my child's file.

Parent signature **Date**

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly Press Hard

STUDENT ID NUMBER OSIS

TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | Sex ☐ Female ☐ Male | Date of Birth *(Month/Day/Year)* __ / __ / __

Child's Address | Hispanic/Latino? ☐ Yes ☐ No | Race *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other

City/Borough | State | Zip Code | School/Center/Camp Name | District Number | Phone Numbers *Home* *Cell* *Work*

Health insurance (including Medicaid)? ☐ Yes ☐ No | ☐ Parent/Guardian ☐ Foster Parent | Last Name | First Name

TO BE COMPLETED BY HEALTH CARE PROVIDER *If "yes" to any item, please explain (attach addendum, if needed)*

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: ______ weeks gestation

☐ Complicated by ______

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)*

☐ Foods *(list)*

☐ Other *(list)*

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

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

If persistent, check all current medication(s): ☐ Inhaled corticosteroid ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Other *(specify)* ______

Explain all checked items above or on addendum

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

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

PHYSICAL EXAMINATION

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

General Appearance:

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

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)* ☐ Within normal limits

If delay suspected, specify below

☐ Cognitive *(e.g., play skills)*
☐ Communication/Language
☐ Social/Emotional
☐ Adaptive/Self-Help
☐ Motor

SCREENING TESTS	Date Done	Results
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	__/__/__	______ µg/dL
	__/__/__	______ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	__/__/__	☐ At risk *(do BLL)* ☐ Not at risk
Hearing ☐ Pure tone audiometry ☐ OAE	__/__/__	☐ Normal ☐ Abnormal
— Head Start Only —		
Hemoglobin or Hematocrit *(age 9–12 mo)*	__/__/__	______ g/dL ______ %

	Date Done	Results
Tuberculosis *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school*		
PPD/Mantoux *placed*	__/__/__	Induration ____ mm
PPD/Mantoux *read*	__/__/__	☐ Neg ☐ Pos
Interferon Test	__/__/__	☐ Neg ☐ Pos
Chest x-ray *(if PPD or Interferon positive)*	__/__/__	☐ Nl ☐ Abnl ☐ Not Indicated
Vision *(required for new school entrants and children age 4–7 yrs)*	__/__/__ ☐ with glasses	Acuity *Right* __/__ *Left* __/__ Strabismus ☐ No ☐ Yes

IMMUNIZATIONS – DATES CIR Number of Child

Hep B	__/__/__	__/__/__	__/__/__	__/__/__
Rotavirus		__/__/__	__/__/__	__/__/__
DTP/DTaP/DT		__/__/__	__/__/__	__/__/__
		__/__/__	__/__/__	__/__/__
Hib	__/__/__	__/__/__	__/__/__	__/__/__
PCV	__/__/__	__/__/__	__/__/__	__/__/__
Polio	__/__/__	__/__/__	__/__/__	__/__/__

Influenza	__/__/__	__/__/__	__/__/__
MMR	__/__/__	__/__/__	__/__/__
Varicella	__/__/__	__/__/__	
Td	__/__/__	__/__/__	__/__/__
Tdap __/__/__ Hep A		__/__/__	__/__/__
Meningococcal	__/__/__	__/__/__	
HPV	__/__/__	__/__/__	__/__/__
Other, *Specify*: ______	__/__/__; ______		__/__/__

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet

☐ Restrictions *(specify)* ______

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

Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision

☐ Other ______

ASSESSMENT ☐ Well Child (V20.2) ☐ Diagnoses/Problems *(list)* **ICD-9 Code**

Health Care Provider Signature | Date __/__/__

DOHMH ONLY PROVIDER I.D.

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

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

Comments

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

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

Telephone (___) ___ - ___ | Fax (___) ___ - ___

REVIEWER:

CH-205 (5/08)

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

New York State Recommended Childhood and Adolescent Immunization Schedule

A check ✓ means that this is the earliest and best time for your child to be immunized. If your child misses the "best time" for vaccination, he or she should still be immunized as quickly as possible. Ask your doctor about getting your child caught up.

	Age							
Vaccine against:	Birth	2 months	4 months	6 months	12 months	18-24 months	4-6 years	11-12 years
Hepatitis A					✓	✓		
Hepatitis B	✓	✓ 1-4 mo.		✓ 6-18 mo.	Recommended for any child not previously vaccinated against Hepatitis B virus.			
Diphtheria, Tetanus, Pertussis (DTaP)		✓	✓	✓	✓ 12-18 mo.		✓	
Haemophilus influenzae type b (Hib)		✓	✓	✓ 1	✓ 12-15 mo.			
Polio (IPV)		✓	✓	✓ 6-18 mo.			✓	
Pneumococcal Disease (PCV)[2]		✓	✓	✓	✓ 12-15 mo.	Ask your doctor if your child 2 years old or older should get vaccinated with PPSV.[2]		
Measles, Mumps, Rubella (MMR)					✓ 12-15 mo.		✓	
Varicella (Chickenpox)					✓ 12-15 mo.		✓	A second catch-up dose is recommended for any child who has had only one dose.
Rotavirus		✓	✓	✓ 1				
Tetanus, Diphtheria, Pertussis (Tdap)								✓ 11-18 yrs.
Meningococcal Disease (MCV4)[3]						Ask your doctor if your child 2 years old or older should get vaccinated with MCV4.[3]		✓
Human Papillomavirus (HPV)								✓ 4
Influenza				Recommended yearly for all children aged 6 months and older. Ask your doctor if your child should receive one or two doses.				

[1]For some types of Hib and Rotavirus, the 6-month dose is not needed.
[2]PCV = Pneumococcal Conjugate Vaccine;PPSV = Pneumococcal Polysaccharide Vaccine
[3]MCV4 = Meningococcal Conjugate Vaccine
[4]The HPV vaccine is given through a series of three shots over a 6-month period. It is now recommended for boys and girls.

This schedule is aligned with national guidelines set by the Advisory Committee on Immunization Practices and recommendations by the CDC.

Imagine Early Learning Centers
Family Handbook Acknowledgement

I acknowledge that I have received the Imagine Family Handbook and Enrollment Package. I acknowledge that it is my responsibility to read and understand these documents. If I have any questions regarding any of the policies, I will discuss them with the Director. I understand that my continued eligibility for enrollment at the Center is contingent upon my following these policies.

I am aware of the Center's Emergency Evacuation procedure.

Parent (1) Signature Date

Parent (2) Signature (if applicable) Date