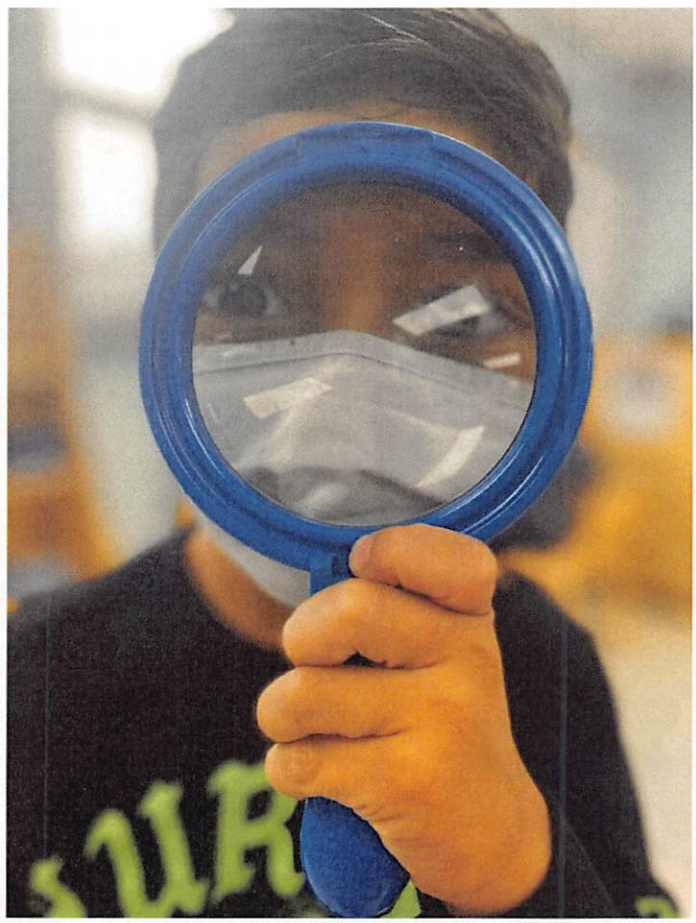
# SMALL WORLD EARLY CHILDHOOD CENTER
# APPLICATION

211 Ainslie Street Brooklyn NY 11211


## Margo Ayinde

Early Childhood Director
mayinde@stnicksalliance.org
718.963.0330 ext 12


Aim High!
There Is Room At The Top!



**For Office Use: FY_____ DATE:_____**

# Small World Early Childhood Center


**718.963.0330**

**211 Ainslie Street, Brooklyn, NY 11211**

- Margo - Program Director.....*mayinde@stnicksalliance.org*.....x 12
- Christine - Behavior Specialist.....*cyoussef@stnicksalliance.org*.....x 23
- Marilyn - Family Coordinator.....*mrodriguez@stnicksalliance.org*.....x 684
- Wendy - Family Coordinator.....*wconcepcion@stnicksalliance.org*..... x 11
- Zakia - Administration Asst.....*zgressman@stnicksalliance.org* .....x 975
- Classrooms Extensions: 201( x22 ) , 202 ( x14), 203 ( x15 ), 205 ( x16 ) 301 ( x18 ), 302 ( x19 ), 303 ( x20 ), 304 ( x900 ), 305 ( x21)


Dear Parent or Guardian,

Our Child Care School Program is for children between 2 and 4 years of age. Please print, complete and sign the forms included, then submit a FULL package to our office. An initial payment should be made on the first day of school, please make checks or money orders payable to: **St Nicks Alliance.** If you are interested in autopayments please ask the office for an EFT form. If you have any questions or concerns, please feel free to give us a call at 718.963.0330.

**Child Care Program Application Checklist:**

- ☐ Provide a copy of the child's Birth Certificate or passport
- ☐ Family Profile/Health Information (attached)
- ☐ Authorized Escort List (attached) *
- ☐ General Trip Consent Form (attached)
- ☐ Photo Release Consent Form (attached)
- ☐ Child/Adolescent Health Exam form ( **MUST** be completed by doctor annually - attached)
- ☐ Child & Adult Care Food Program Form ( **IMPORTANT** ) **
- ☐ Review and sign the Family Manuel
- ☐ 3K and UPK(4k) must also fill out a DOE application and provide 2 Proofs of Address ( i.e, ID, utility bills, lease, paystubs, NO medical papers)

** For your child's protection, we will not allow your child to leave with a person who is not on file in the main office or if we have not received a phone call/email from a parent or guardian identifying the new person who will be picking up your child. ** Child & Adult Care Food Program Form is a very important source of funding for our school. If you believe you do not qualify we kindly ask to still complete the form. Thank you*

For Office Use: FY_____ DATE:_____

# Family Profile Form

1. ***Child Information:***

**Child's Name: _____**

**Date of Birth: _____Gender:_____**

**Home Address: _____**

**Best Contact Number: _____Primary Language: _____**

2. ***Please select meals:***

**❒ Breakfast ❒ AM-Snack ❒ Lunch ❒ PM-Snack**

3. ***Child's Schedule:*** **Morning Drop off is 8:15AM for 2k, 8:30AM for 3k - 4k**

***Choose a Pick-Up time:*** ***(PLEASE call or email ahead to BOTH the classroom & the office if arriving late):***

**❒ 2:50PM OR ❒4:30PM OR ❒5:15PM OR ❒6:00PM**

***2. Parent/Guardian Information:***

**4a.Parent/Guardian Name: _____**

**Home Address ( if different from above ): _____**

**_____**

**Best Contact Number: _____**

**Best Email: _____**

**Employer Name/Address: _____**

**Work Telephone: _____ Hours at Work From: _____To:_____**

.....

**4b.Parent/Guardian Name: _____**

**Home Address ( if different from above ):_____**

**_____**

**Best Contact Number: _____**

**Best Email: _____**

**Employer Name/Address: _____**

**Work Telephone: _____ Hours at Work From: _____To:_____**

For Office Use: FY_____ DATE:_____

## Home Information

- Child's Name ( First, Last ): _____
- Name child likes to be called: _____
- Does your child have any food or medical allergies? *( Peanuts, milk, chocolate, etc )* : _____
- Does your child require medication to be given during the time they are in school? _____
- Has your child had any serious injuries, illness or corrective procedures? Describe ( please provide dates and specifies ):

_____

_____

- Has your child been hospitalized? YES | NO
- If Yes, Describe ( please provide dates and specifice of hospitalization ):

_____

_____

- Is your child currently receiving medical treatment ? YES | NO
- If Yes, Please describe ( be specific ): _____

_____

- Is your child able to fully participate in all aspects of the program? (outdoor play etc ): YES | NO . If not, please specify restriction:

_____

- Siblings Name: _____ Age: _____
  _____ Age: _____
  _____ Age: _____
- Describe your child's attitude toward sibling(s): _____

_____

- Please describe the child's relationship with each parent: _____

_____

- What is your current childcare arrangement? _____

_____

- How many hours per week? _____
- What languages are spoken at home ? _____
- Do you currently have any custody agreements, court order or restraining orders pertaining to the child? YES | NO *( please attach paperwork if needed )*

For Office Use: FY_____ DATE:_____

## Social Emotional Development

- Will your child play contentedly alone?

_____

- Approximately how long can the child play alone ? _____
- Does your child have regular playmates ? YES | NO, Ages: _____
- Where do they usually play? _____
- Were you pleased with the previous child care experience(s) ? _____

If not, what would you have preferred? _____

_____

- How many hours of screen time is your child allowed daily? _____
- Do they have favorite electronic games or TV programs?

_____

- Please list child's favorite hobbies, activities or interests:

_____

- Is your child toilet trained? YES | NO - Are they having accidents? YES | NO
- How often? _____ At night? _____ At nap? _____
- How does your child tell you they need to use the bathroom?

_____

- Are there issues/concerns with your child going to the bathroom ?

_____

- Describe your child's eating habits: _____
- What do you do if your child refuses a particular food?
- Does your child eat with the family? YES | NO
- Does your child sleep through the night? YES | NO. If No, why does the child usually wake up? _____
- How long would they stay awake? _____
- Does your child have a naptime routine? Describe:

_____

For Office Use: FY_____ DATE:_____

- Can your child dress themselves? YES | NO, To what extent?

_____

- How has your child handled separating from you ( in school, babysitting, camp, etc. ) and what things do you say or do to ease the separation? _____

_____

- Briefly describe your child's personality and temperament: _____

_____

_____

- Is there anything particular about their behavior that you feel is unique or important for us to know about ? _____

_____

_____

- Please share any event that has occurred that may have impacted your child's life: _____

_____

_____

- What are you hoping your child will learn from attending this child program?_____

_____

_____ _____

Parent or Guardian's Signature Date

For Office Use: FY_____ DATE:_____

## Medical Information

**Pediatrician Name:** _____

**Pediatrician Telephone Number:** _____ **Fax Number:** _____

**Pediatrician Address:** _____

**Allergies/Special Diet:** YES | NO (If yes, please explain) _____

**Individual Health Plan for Child with a chronic health condition? YES | NO**

**( if yes, please attach ):** _____

**Special Limitations or Concerns:** YES | NO

**( if yes, please explain ):** _____

**Does your child have an IEP ( Individualized Education Plan *)? YES | NO**

*If your selected yes or may have concerns about any of the related services below please check:

❒ Early Intervention ❒ Occupational Therapy ❒Speech/Language ❒Physical Therapy ❒None

.....

## Emergency Medical Care

I understand that every effort will be made to contact me in the event of an emergency requiring medical treatment, including but not limited to an epinephrine auto-injection for suspected exposure to a life threatening allergen for my child when delay would be dangerous to the health of my child. In the event that I cannot be reached, I hereby authorize Small World Early Childhood Center to transport my child to the nearest medical care facility and/or to _____, To seek medical treatment for my child. *In addition to the authorized escort list - in the event that Small World cannot contact either parent/guardian, please provide two relatives or a family friend that will assume responsibility for my child.

**Name:**_____ **Relation to Child:** _____
**Address:** _____ **Phone:** _____

**Name:**_____ **Relation to Child:** _____
**Address:** _____ **Phone:** _____

For Office Use: FY_____ DATE:_____

**Photo Release Consent: Please circle -> ACCEPT / DECLINE**

## If accept please fill out:

**Student Name: _____**

**I hereby consent to taking photographs, movies or video tapes of the student named above by Small World Early Childhood Center. I also grant the right to edit, use, and resume said products for non-profit purposes including use in print, on school website, internet, and all other forms of media.**

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

**Address of Parent/Guardian: _____**

.....

**General Trip Consent Form : ACCEPT / DECLINE**

**I hereby give permission to my child, _____**

**( child's name )**

**who was born on ____/____/____ to go on any school trips and/or daily park trips with Small World Early Childhood Center located at 211 Ainslie Street, Brooklyn, NY, 11211, by means of walking, on any given school day for the current School year of _____.**
**Should it be necessary I give permission for my child to receive emergency medical treatment while in the care and custody of Small World while they are on this trip. I understand, I will be notified of the need for emergency medical treatment immediately.**

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

**Print Name of Parent: _____ Daytime Phone#:_____**

******Please note additional permission slips will be given for individual field trips******

For Office Use: FY_____ DATE:_____

# Authorized Escort List Form

The New York City Health Code requires child care centers to obtain and maintain, for every child, a list of all persons authorized by the parent/guardian to escort the child from child care. The child care center shall not release any child to any individual who has not been identified by the parent/guardian as a person who is authorized to escort a child out of the center*.

*Instructions*: The parent/guardian must complete, sign, and return this form to the child care center upon enrollment and update this form immediately when there is any change in authorized persons. **Please inform those on this list that we require proper photo identification in order to release your child.* **You do not need to use all five slots.**

**I, _____, authorized Small World to release my child,**

**( parent name/s )**

**_____ ONLY to the individuals I have Identified below:**

**( child name )**

**1. Name: _____ Relationship to Child:_____**
**Address:_____**
**Best Contact #: _____**

**2. Name: _____ Relationship to Child:_____**
**Address:_____**
**Best Contact#: _____**

**3. Name: _____ Relationship to Child:_____**
**Address:_____**
**Best Contact#: _____**

**4. Name: _____ Relationship to Child:_____**
**Address:_____**
**Best Contact#: _____**

**5. Name: _____ Relationship to Child:_____**
**Address:_____**
**Best Contact#: _____**

**For Office Use: FY_____ DATE:_____**

Dear Family and Physician,

The NYC Department of Health and Department of Education requires that ALL children attending school based programs have a medical exam on an annual basis. Please complete ALL sections on the attached form including:

- ☐ All Vaccinations
- ☐ Hearing Test
- ☐ Vision Test
- ☐ Height, Weight and Body Mass Index (BMI)
- ☐ Lead Test Results ( from prior years if applicable)

If the child has an allergy or asthma, please complete and attach the following:

- ☐ Allergy response Treatment Plan
- ☐ Asthma Action Plan

Please submit the completed Medical form, signed and dated by the medical staff to the office.

Thank you, Small World Early Childhood Center

# 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

| *NI Abnl* | *NI Abnl* | *NI Abnl* | *NI Abnl* | *NI 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 | ___/___/___ | ☐ *NI* ☐ *Abnl* ☐ *Referred* |
| OAE | ___/___/___ | ☐ *NI* ☐ *Abnl* ☐ *Referred* |
| ≥ 4 yrs: pure tone audiometry | ___/___/___ | ☐ *NI* ☐ *Abnl* ☐ *Referred* |

| **Vision** | *Date Done* | *Results* |
|---|---|---|
| <3 years: Vision appears: | ___/___/___ | ☐ *NI* ☐ *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#**