華僑社會福利社
IMMIGRANT SOCIAL SERVICES, INC.
137 Henry Street, New York, N Y 10002
Tel: (212) 571-1840 · (212) 571-1846 · (212) 571-0272 · Fax: (212) 571-1848
Email info@issnyonline.org / Website www.issnyc.org

Student Application 課後補習班及暑期夏令營表格

School Site 選擇學校:	□ PS 2	□ PS 42	□ PS 126	□ PS130
Program 課程:	□ After school	□ Summer school		□ Other ______________

Child's Name ____ Male ___ 男 Female ___ 女
學生姓名 English Name/ 英文名字 Chinese Name/ 中文名字

Address 住址 ____
Street Apt# City/State Zip

Home Phone 電話____________________School Attending 就讀學校 _____________ Grade 年級 ______

Date of Birth 出生日期 ______________ Age 年齡 ____

Language Spoken at Home English, Mandarin, Cantonese, Fujianese, Spanish
在家講的語言 英語，國語，廣東話，福建話，西班牙語。

Father/Guardian Name ______________________________ Phone# ___________________
父親/監護人姓名 電話號碼
Messaging app: WhatsApp, WeChat 微信, iMessage, Hangouts

Mother/ Guardian Name______________________________ Phone# __________________
母親/監護人姓名 電話號碼
Messaging app: WhatsApp, WeChat 微信, iMessage, Hangouts

EMERGENCY INFORMATION: Name of Person to Contact in the Event of an Emergency during program time
緊急聯絡資訊：課程時間緊急通知人姓名及資料

Name ____ Relationship: ______________
姓名 English Name/ 英文名字 Chinese Name/ 中文名字 關係

Address 住址 ____
Street Apt# City/State Zip

Work: _________________ Home: ___________________ Mobile: __________________________
工作 家里 手機
Messaging app: WhatsApp, WeChat 微信 , iMessage, Hangouts

Name ____ Relationship: ______________
姓名 English Name/ 英文名字 Chinese Name/ 中文名字 關係

Work: _________________ Home: ___________________ Mobile: __________________________
工作 家里 手機
Messaging app: WhatsApp, WeChat 微信, iMessage, Hangouts

LETTER OF CONSENT 同意書

My son/daughter________________________________is presently a registrant attending the after-school/Summer Camp Programs at Immigrant Social Services Inc. I, as parent or legal guardian, authorize you on my behalf to make necessary decisions concerning the safety of my child in case of any emergency during program hours. I also understand and agree that after the program hour/dismissal time, my child will walk home by him/herself, or will be picked up by a designated person arranged by myself. The agency bears no responsibility for the child after dismissal. (Office of Children and Family services Regulation 414.8(g).)

我的兒子女兒________________________________參加華福社舉辦的課後補習班及暑期夏令營，我本人身為孩子的家長或合法監護人，授權給華福社在課後補習班及暑期夏令營的時間當有緊急情況發生，為本人孩子的安全作必要的決定。我也了解而且同意我的孩子在放學或解散後，自己走路或被我所指定的代理人接送回家。華福社在放學或解散後，對您的孩子不負任何責任。

I grant permission for my child to use all equipment and participate in all activities at ISS programs.
我准許我的小孩使用華福社所有的設備及參加華福社所有的活動。

I grant permission for my child to leave the school premises under adequate supervision by staff for neighborhood walks or parks and for trips. It is my understanding that these trips may be taken at any time without further consent from me.
我准許我的小孩在足夠工作人員前提下，離開學校去鄰近地區公園散步和旅行。我了解這些旅行會在沒有進一步通知我的情況下發生。

I grant permission for my child to leave the school premises for field trips, i.e. library, movies, etc.
我准許我的小孩為了去旅行而離開學校，例如去圖書館，看電影等。

Immigrant Social Services is open to all students, however if we deem a child exhibiting unsafe behavior to himself/herself, peers and adults in the school, we will require additional parental support in the classroom and on field trips. Field trip expenses must be paid for by the parent/guardian. If this partnership is unmet, Immigrant Social Services reserve the right to discharge your child from our program.

華僑社會福利社對所有學生開放，但是，如果我們認為學生在學校對自己，同伴和成人有不安全行為，我們將要求父母在課堂上和旅遊/實地考察時有更多的支持。旅遊/實地考察的費用必須由家長/監護人支付。如果是次合作未得到滿足，華僑社會福利社將保留學生被要求終止參加課程的權利。

Signature 簽名 ________________________________ Date 日期 ______________________

DISMISSAL PROCEDURE 解散程序

Name of Authorized Person to Pick Child up 授權代理接送學生的姓名

Name 姓名	Relationship 關係
1. ________________________________	________________________ (parent/sibling/uncle/aunt/grandparent/cousin/nanny)
2. ________________________________	________________________ (parent/sibling /uncle/aunt/grandparent/cousin/nanny)
3. ________________________________	________________________ (parent/sibling /uncle/aunt/grandparent/cousin/nanny)

□ *Child Will Go Home Alone

CONSENT TO PHOTOGRAPH/VIDEO/INTERVIEW 同意照相/錄影/訪問

The ISS After-school/Summer Program may have programs that include special events in and outside the school. In such an event, it is possible that the media, in the form of television, newspaper or journals may be invited, or may appear of their own accord to document such an event. In these cases, they might photograph, video or interview your child and such may be used to promote the ISS After-school/Summer Program.
華福社課後補習班及暑期夏令營課程可能會有包括其他另外的課程活動，這個課程包含在校內和校外的特別活動，如果有特別活動時，我們可能會邀請電視、報社或新聞雜誌媒體來采訪，他們媒體也可能為了記錄這項活動自己來參與，他們可能會照相、錄影或訪問您的小孩，這些是為了提升華福社課後補習班及暑期夏令營課程活動。

I give permission for my child to be photographed/videoed or interviewed in the event of these special programs. 我准許媒體在這些特別活動中拍攝或錄影我的小孩。

I have read and fully understand the statements above and the policies detailed.

Signature 簽名 ________________________________ Date 日期 ______________________

HEALTH RECORD FOR CHILDREN IN DAY CAMPS & AFTERSCHOOL & YOUTH CENTERS

(This side to be filled in by parent before presentation to physician)

NAME OF PROGRAM ______________________________

______	______	/ /	M ❑ F ❑
CHILD'S LAST NAME	FIRST NAME	BIRTHDATE	SEX

Home Address: ______________________________ Phone: ______________

Parent or Guardian: ______________________________ Phone: ______________

Place of Employment: Father (Guardian) ______________________ Phone: ______________

Mother (Guardian) ______________________ Phone: ______________

In case of emergency, notify: ______________________ Phone: ______________

If Parent, Guardian are not available in an emergency, notify:

1. ______________________ Phone: ______________

or 2. ______________________ Phone: ______________

Important: Has this camper been exposed to any communicable disease during the three weeks prior to camp attendance:
Yes ❑ No ❑ (If yes, state type of exposure: ______________________)

HEALTH HISTORY: (Check box if child has had afflictions, give appropriate dates)

	Allergies
❑ Rheumatic Fever ______	❑ Hay Fever ______
❑ Seizures ______	❑ Poison Ivy, etc. ______
❑ Diabetes ______	❑ Insect Stings ______
❑ Asthma ______	❑ Penicillin ______
❑ Chicken Pox ______	❑ Other Drugs ______
	❑ Food ______

Other Past Illnesses ______________________________

Operations or Serious Injuries (Dates) ______________________________

Hospitalization (Dates) ______________________________

Chronic or Recurring Illness ______________________________

Any specific activities to be encouraged? ______________________________

Conditions that require activity to be restricted? ______________________________

Permission for all program activities unless otherwise noted by Dr. ______________________________

Appliance worn (glasses, contacts, etc.) ______________________________

Medication taken ______________________________

Suggestion from Parent/Guardian ______________________________

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I do hereby give authority to the Day Camp and Year Round Afterschool and Youth Center Program staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Relationship ____________ Signature ______________________ Date ____________ Tel.# ______________

Department of Health and Mental Hygiene — The City of New York — Bureau of Food Safety and Community Sanitation

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 corticosteriod ☐ 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 ☐☐☐☐☐☐☐☐☐

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

Vaccine	Dates		
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 __ __/__ __/__ __

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

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (__ __ __) __ __ __ – __ __ __ __ | Fax (__ __ __) __ __ __ – __ __ __ __

DOHMH ONLY **PROVIDER I.D.** ☐☐☐☐☐☐

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

Comments

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

REVIEWER:

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