華僑社會福利社2019年暑期班

招生對象: 升讀幼稚園至8年級
時間：星期一至星期五 | 早上9:00-下午5:45
地點：42號公立小學 | 紐約市海斯特街71號

提前報名優惠計劃

日期：7月1日起至8月16日 ~~$1400~~ **$1250**
延長一週至8月23日 ~~$1500~~ **$1400**
5月1日截止

課程安排特點

上午主題: 學業成功之路

採用公校老師設計的英語、數學輔導教材，幫助孩子提高數學及英語閱讀寫作能力，並建立良好的做功課和學習習慣，讓他們在新學年取得成功。

下午主題:「做中學、學中做」

讓孩子嘗試新的事物及各種活動，跟著好奇心，探索自己的興趣，包括創意美術、游泳、戶外參觀旅遊活動、科學遊戲和其它多樣性和趣味性的的活動！

更多優惠

※同一戶家庭第二子女或以上報名可以享受$25優惠。
※舊生家庭成功推薦新家庭報名可享$20優惠(限一次)。
※每位暑期班學生報名2019-20 課後輔導班可享$50優惠。
※接受ACS /人力資源管理局托兒憑劵。
※歡迎家長詢問提前送孩子的選擇及分期付款或學費補助的需求。

報名及資詢

週一至週五下午3時至6時。親自到校或透過電話報名都可。到校後請找華僑社會福利社員工。

42號公立小學
海斯特街71號 | (917) 828-2213

2號公立小學
亨利街122號 | (917) 828-2672

126號公立小學
嘉薩琳街80號 | (917) 838-6107

130號公立小學
巴士打街143號 | (212) 219-1662

課程由紐約市健康與心理衛生局認證具有學齡兒童許可證School Age Child Care License (S.A.C.C.)機構合格經營。工作人員具有心肺復甦法訓練認證。

Immigrant Social Services, Inc.
華僑社會福利社

Student Registration Form
課後輔導及暑期班報名表

School Site: ☐ PS 2 ☐ PS 42 ☐ PS 126 ☐ PS 130 Program: ☐ Afterschool ☐ Summer School Year:

Child's Name 學生姓名: (中文):

Gender 姓別: ☐ Male 男 ☐ Female 女 D.O.B.出生日期: / / Grade 年級:

Address 住址: City/State 城市/州: Zipcode 郵政編碼:

Current School 就讀學校: ELL: ☐ Yes 是 ☐ No 不是 IEP: ☐ Yes 有 ☐ No 沒有

Primary Languages at Home 家庭的主要語言: ☐ English 英語 ☐ Mandarin 國語/普通話 ☐ Cantonese 廣東話 ☐ Fujianese 福建話 ☐ Spanish 西班牙語 ☐ Other 其它:

Has your child participated in ISS programs before? 你的孩子以前參加過華僑社會福利社輔導班嗎？ ☐ Yes 有 ☐ No 沒有 If yes, which year? 如有，請填年份

If your child is enrolled for the first time, how did you hear about our program? 如果小孩是華僑社會福利社輔導班新生，您是透過那裏得知我們的活動？

If someone referred you, please tell us their name? 如受人推薦，請填寫推薦人姓名。

PRIMARY PARENTS/GUARDIANS INFORMATION 主要家長/監護人資料

1.Name 姓名: (中文): Relationship 關係

Phone # 電話號碼: 微信/WhatsApp: Email:

2.Name 姓名: (中文): Relationship 關係

Phone # 電話號碼: 微信/WhatsApp: Email:

EMERGENCY CONTACTS 緊急聯絡人

1.Name 姓名: (中文): Relationship 關係

Phone # 電話號碼: Additional Phone # 其它電話號碼: 微信/WhatsApp:

2.Name 姓名: (中文): Relationship 關係

Phone # 電話號碼: Additional Phone # 其它電話號碼: 微信/WhatsApp:

PICKUP AUTHORIZATION 接送學生授權表格

The following individuals have my permission to pick up my child. (Photo ID required.)
我允許下列人士接送我的子女。（需出示身分證明。）

1.Name **姓名:**	Phone # **電話號碼:**	Relationship **關係:**
2.Name **姓名:**	Phone # **電話號碼:**	Relationship **關係:**
3.Name **姓名:**	Phone # **電話號碼:**	Relationship **關係:**

☐ I authorize my child to leave on his/her own after the program is over for the day. (Must be age 11 or older.)
我准許我的子女活動完畢後自己回家（學生必須 11 歲或以上。）

☐ I authorize my child to sign out his/her younger sibling(s) and leave together after the program is over for the day. **我准許我的子女活動完畢後帶他的弟妹一起回家。**

____
Signature of Parent/Guardian **家長/監護人簽名**

LETTER OF CONSENT **輔導班同意書**

My son/daughter _____________________________ is presently a registrant attending the after-school/summer 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).)

I grant permission for my child to use all equipment and participate in all activities at ISS programs.

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.

I grant permission for my child to leave the school premises for field trips, eg. library, movie theater, etc. Immigrant Social Services, Inc. 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, Inc. reserves the right to discharge your child from our program.

我的兒子/女兒_____________________________參加華福社舉辦的課後補習班及暑假夏令營，我本人身為孩子的家長或合法監護人，授權給華僑社會福利社在課後補習班及暑假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。我也解而且同意我的孩子在放學或者解散後，自己走路或被我所指定的代理人接送回家。華福設在放學或解散後，對您的孩子不負責任。

我准許我的小孩使用華華僑社會福利社所有的設備及參加華福社所有活動。

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。

我准許我的小孩為了去遠足或戶外教學而離開學校，例如去圖書館，看電影等。

所有學生都可參加華僑社會福利社的輔導班和活動，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。如果這次合作未得到滿足，華僑社會福利社將保留學生被要求終止參加課程的權利。

CONSENT TO PHOTOGRAPH/VIDEO/INTERVIEW 照相/錄影/訪問同意書

ISS Afterschool/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 or 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 Afterschool/Summer Program.

Please check one:

☐I give permission for my child to be photographed/videoed or interviewed in the event of these special programs and for ISS website, social media, and brochures.

☐I do not give permission for my child to be photographed/videoed or interviewed in the event of these special programs for ISS website, social media, and brochures.

華僑社會福社課後補習班及暑期班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，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採訪，他們媒體也可能為了記錄這項活動自動來參與，他們可能會照相· 錄影或訪問你的小孩，這些是為了提昇華福社課後補習班及暑期夏令營課程活動。

請選一:

☐我准許我的孩子的照片或錄影出現在媒體或華僑社會福社的網站、社群媒體台和刊物。

☐我不准許我的孩子的照片或錄影出現在媒體或華僑社會福社的網站、社群媒體台和刊物。

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

我明白和同意華僑社會福社補習班課程和活動的政策。

______________________________ ______________________

Signature of Parent/Guardian 家長/監護人簽名 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 ______________________________

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

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)

- ❑ Rheumatic Fever ____________
- ❑ Seizures ____________
- ❑ Diabetes ____________
- ❑ Asthma ____________
- ❑ Chicken Pox ____________

Allergies

- ❑ Hay Fever ____________
- ❑ Poison Ivy, etc. ____________
- ❑ Insect Stings ____________
- ❑ Penicillin ____________
- ❑ 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.# ____________

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

Vaccine			
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