



ENRICHMENT CENTER

CHILD RELEASE FORM TO AFTERSCHOOL

Parent – Please make a copy and give it to your child’s teacher. Return a copy to KL

CHILD’S NAME _____

CHILD’S CLASS _____

CHILD’S SCHOOL _____

DAYS ATTENDING (Please Circle): **MON TUE WED THURS FRI**

My child will be attending Kuei Luck After School. Please release my child to their program.
Drop off instructions are school specific. Please check with your school administration.

Thank you for your cooperation and support. We look forward to working with you.

Sincerely,

Kuei Luck Enrichment Center

718-679-9908 | www.kueiluck.com | info@kueiluck.com



Authorized Escorts 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 escort information.

I, _____, authorize this child care center to release my child, _____, to the individuals I have identified below.
(parent/ guardian name)
(child name)

Form with fields: Name, Relationship to child, Home address, Preferred contact (checkboxes for Mobile/Cell Telephone, Home Telephone, Work Telephone, Text (Mobile), E-mail), Telephone (Mobile/Cell, Home, Work), E-mail.

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Parent/ Guardian Signature: _____

Date: _____

In accordance with the requirements of the New York City Health Code, Article 47, Section 47.57(h)(1) child care centers must obtain and maintain for every child a list of the name, relationship to child, address and contact information of every person the parent has authorized to escort a child from the child care service. The permittee shall not release any child to any individual who has not been identified by the parent(s)/guardian(s) as a person who is authorized to escort a child out of the service.

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 Date of Birth
Child's Address Hispanic/Latino? Race
City/Borough State Zip Code School/Center/Camp Name District Number Phone Numbers
Health insurance Parent/Guardian Last Name First Name Email

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history (age 0-6 yrs) Does the child/adolescent have a past or present medical history of the following?
Allergies
Attach MAF in in-school medications needed

PHYSICAL EXAM Date of Exam: General Appearance:
Height Weight BMI Head Circumference
Blood Pressure

DEVELOPMENTAL (age 0-6 yrs) Nutrition Hearing Vision
Describe Suspected Delay or Concern:
Child Receives EI/CPSE/CSE services

IMMUNIZATIONS - DATES
DTP/DTaP/DT Tdap
Polio Hep B Hib PCV Influenza HPV
Mening ACWY Hep A Rotavirus Mening B
Other

ASSESSMENT Well Child (Z00.129) Diagnoses/Problems (list) ICD-10 Code
RECOMMENDATIONS Full physical activity
Restrictions (specify)
Follow-up Needed
Referral(s):

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#

Kuei Luck Enrichment Center

Emergency Contact Card

Updated Yearly and As Needed

PHOTO OF CHILD (Optional)	PROGRAM NAME:	ADDRESS:	PHONE NUMBER: () -	
	CHILD'S FULL NAME:		DATE OF BIRTH: / /	
	PREFERRED NAME/NICKNAME:		GENDER:	
	CHILD'S HOME ADDRESS:			
NAME OF PERSON ENROLLING CHILD:		RELATIONSHIP TO CHILD: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Caretaker <input type="checkbox"/> Relative _____ <input type="checkbox"/> Other _____		
PHONE NUMBER(S) OF PERSON ENROLLING CHILD: () - <input type="checkbox"/> ok to text		ADDRESS OF PERSON ENROLLING CHILD (IF DIFFERENT THAN CHILD):		
EMAIL ADDRESS:				
EMERGENCY INFO	EMERGENCY CONTACT NAMES / ADDRESSES	Authorized to Pick Up Child	PRIMARY PHONE NUMBER	OTHER PHONE NUMBER / EMAIL
	PRIMARY CONTACT:	<input type="checkbox"/> Yes <input type="checkbox"/> No	() - <input type="checkbox"/> ok to text	() - <input type="checkbox"/> ok to text
		<input type="checkbox"/> Yes <input type="checkbox"/> No	() - <input type="checkbox"/> ok to text	() - <input type="checkbox"/> ok to text
		<input type="checkbox"/> Yes <input type="checkbox"/> No	() - <input type="checkbox"/> ok to text	() - <input type="checkbox"/> ok to text
FOR PROGRAM USE ONLY		FOR PROGRAM USE ONLY		
DATE OF ENROLLMENT: / /		DATE OF DISENROLLMENT: / /		

CHILD'S FULL NAME:	DATE OF BIRTH: / /
Check boxes below to indicate if your child has any special needs/services: <input type="checkbox"/> None <input type="checkbox"/> Early Intervention/Special Education <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech/Language <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Allergies (Please list) _____ <input type="checkbox"/> Other _____ Please provide information here AND discuss with your child care provider:	
CHILD'S PRIMARY CARE PHYSICIAN'S NAME/ GROUP:	PHONE NUMBER: () -
PREFERRED HOSPITAL:	PHONE NUMBER: () -
CHILD'S DENTAL CARE:	PHONE NUMBER: () -
AGREEMENTS <ul style="list-style-type: none"> • I consent to emergency medical treatment for my child..... <input type="checkbox"/> Yes <input type="checkbox"/> No • I consent for my child to take part in neighborhood trips (i.e., library, park and playground) away from the program under proper supervision..... <input type="checkbox"/> Yes <input type="checkbox"/> No • I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips..... <input type="checkbox"/> Yes <input type="checkbox"/> No • I provided information on my child's special needs to the program to assist in caring for my child..... <input type="checkbox"/> Yes <input type="checkbox"/> No • I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation..... <input type="checkbox"/> Yes <input type="checkbox"/> No • I agree to review and update this information whenever a change occurs and at least once every year..... <input type="checkbox"/> Yes <input type="checkbox"/> No 	
SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:	DATE: / /