

## 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**



Date: \_\_

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. \_\_\_\_\_, authorize this child care center to release my child, (parent/ quardian name) , to the individuals I have identified below. (child name) Name: Relationship to child: Home address: ☐ Home Telephone ☐ Mobile/Cell Telephone ☐ Work Telephone Preferred contact: ☐ Text (Mobile) □ E-mail Mobile/Cell: Telephone: Work: Home: E-mail: Name: Relationship to child: Home address: ☐ Mobile/Cell Telephone ☐ Home Telephone ■ Work Telephone Preferred contact: ☐ Text (Mobile) □ E-mail Mobile/Cell: Telephone: Home: Work: E-mail: Parent/ Guardian Signature: \_\_\_\_\_

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 HE NYC DEPARTMENT OF HEALTH & MENTAL HYC	EALTH	H EXAMI - DEPARTMEI	NATION NT OF EDUCA	I FO	RM Ple Print Cle	ease early	NYC ID (OSIS)									
TO BE COMPLETED BY THE PA	RENT	OR GUAR	DIAN								·					
Child's Last Name First Name				Middle Name				Sex	Sex							
Child's Address					Hispanic/Latin	Hispanic/Latino? Race (Check ALL that appl)  ☐ Yes ☐ No ☐ Native Hawaiian/Paci					☐ Asian ☐ Black ☐ White					
City/Borough	State	Zip Code School/C			Center/Camp Name	enter/Camp Name			District Number		Phone Numbers Home					
Health insurance ☐ Yes ☐ Parent/Guardian (including Medicaid)? ☐ No ☐ Foster Parent	Last Name	ne First Name				Email						Cell				
TO BE COMPLETED BY THE HEALT	H CAR	E PRACTITI	ONER													
Birth history (age 0-6 yrs)	1	Does the child/	adolescent h		oast or present m	· · · · · · · · · · · · · · · · · · ·										
☐ Uncomplicated ☐ Premature: weeks gestation		Asthma (check If persistent, check				☐ Intermittent ☐ Mild Persistent ☐ Quick Relief Medication ☐ Inhaled Corticosteroid										
☐ Complicated by		Asthma Control			☐ Well-controlled	F	Poorly Controlled or I	Not Contro	lled							
Allergies  None Epi pen prescribed	IΓ	<ul><li>☐ Anaphylaxis</li><li>☐ Behavioral/mer</li></ul>	ntal health disor	der		Casash basilas surileral largeluses					edications (attach MAF if in-school medication needed)  None					
☐ Drugs (list)		Congenital or a  Developmental	cquired heart d	isorder		☐ Tuberculosis (latent infection or disease)				☐ None ☐ Yes (list below)						
☐ Foods (list)		☐ Diabetes <i>(attac</i> ☐ Orthopedic inju	h MAF)	""	Surgery											
Other (list)		Ortnopedic inju Ex <i>plain all check</i>	ry/disability <i>ed items abov</i> i	e.	Other (specify)											
Attach MAF in in-school medications needed																
PHYSICAL EXAM Date of Exam:/_	/ (	General Appeara	nce:									-				
Height cm (	%ile)			-	ical Exam WNL											
Weight kg (	/ /	<i>NI Abnl</i> □ □ Psychosocial		<i>NI Abnl</i> □ □ HI	EENT	NI AbnI  □ □ Lympi		NI AbnI □ □ Ab	domon		<i>NI AbnI</i> ☐ ☐ Skin					
BMI kg/m² (	_ '	⊒ □ Fsychosociai □ □ Language				Lungs	1		nitourinary		□ □ Skiii □ □ Neuro	logical				
Head Circumference (age ≤2 yrs) <b>cm</b> (	/0110/	□ □ Behavioral	[	□	eck	☐ ☐ Cardio			tremities		☐ ☐ Back/	-				
	_ <sup>/0116)</sup>  I	Describe abnorm	alities:													
Blood Pressure (age ≥3 yrs) / /	I.	Nutrition					Hearing		Dat	te Done		Res	ults			
		< 1 year  Breas	tfed 🗌 Formul	a 🗆 Bo	oth		< 4 years: gros	s hearing		/	/ [ [	VI □Abn		eferred		
☐ Yes ☐ No/_	/	-		-	dance Counseled	☐ Referred	OAE		,			VI □Abn				
Screening Results: WNL		Dietary Restrictio	i <b>ns</b> □ None □	Yes (IIs	st below)		≥ 4 yrs: pure tor	ne audion	netry	_/	/	II □Abn	I □Re	eferred		
Delay or Concern Suspected/Confirmed (specify area(s)		SCREENING TES	TS Dat	te Done	Result	Vision Vision				te Done		Res				
☐ Cognitive/Problem Solving     ☐ Adaptive/Self-Help       ☐ Communication/Language     ☐ Gross Motor/Fine Motor		Blood Lead Level (BLL)			/	<3 years: vision ap				_/	_/ Rig	☐ <i>NI</i> ht	∐ Abr	ıl		
☐ Social-Emotional or ☐ Other Area of Concern:		(required at age 1 yr and 2				/ Acuity (required fo and children age 3				_/	_/ Left	t	_ /	_		
Personal-Social  Describe Suspected Delay or Concern:		yrs and for those at risk)/			/ μg/dL □ At risk (do BLL) Screened with Gla			010	☐ Unable to test							
Describe Suspected Delay of Concern.	1.	Lead Risk Assessment (annually, age 6 mo-6 yrs)  —— Child Ca			, , ,			Screened with Glasses? Strabismus?				☐ Yes ☐ No ☐ Yes ☐ No				
					□ Not	Dental										
					visible Tooth g/dL Urgent need f				forral (pain a	uvallina	infaction)		es [			
Child Dessives EI/CDCE/CCE services	l I	Hemoglobin or Hematocrit			//   Signal Need to Dental Visit w					infection)						
Child Receives EI/CPSE/CSE services Yes	es 🗆 No   '		Physic	cian Cor	nfirmed History of Va		on $\square$				Report only	positive	immu	nitv:		
IMMUNIZATIONS – DATES			,		,							·				
DTP/DTaP/DT / / / /							 Гdap /				IgG Titer			 '		
Td / / / /	-'' '	//_	/	_'	/ MMR	/ /	/ / / / / / / / / / / / / / / / / / /	-' '	/	/	Hepatitis I Measle		//			
Polio / / / /	/ /			/	Varicella			/	/	/	Mump		// /			
Hep B//	//_		/	_/	Mening ACWY		/	/	/	/	Rubella	a	//			
Hib//////	_//	//_	/	_/	Hep A	//	/	_/	/_	/	Varicella	a	//			
PCV//	//	//_	/	_/	Rotavirus	//	/	_/	/_	./	Polio	1	//			
Influenza / / / /	_//	//_	/	_/	Mening B	//	/	_/	/	./	Polio 2	2	//	!		
HPV/ / //	_//	//_	/	_/	Other	/_	/		/	_/	Polio	3	//			
ASSESSMENT Well Child (Z00.129)	Diagnos	ses/Problems (lis	) ICD-10	O Code	RECOMMENDATION		ıll physical activit	y								
					Restrictions (spec		Voc. for				Appt. date: _					
					Referral(s):		arly Intervention		Denta		Vision	'				
			_		Other		,									
Health Care Practitioner Signature					Date Form	Completed	//_		OHMH PRAC	CTITION	ER		I			
Health Care Practitioner Name and Degree (print)				Prac	Practitioner License No. and State				TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)  Comments:							
Facility Name				Nati	National Provider Identifier (NPI)											
Address					State Zip				Date Reviewed: I.D. NUMBER							
Address City				State Zi				RE	VIEWER:					$\perp$		
Telephone	Fax				Email				RM ID#				T			

## **Kuei Luck Enrichment Center Emergency Contact Card** Updated Yearly and As Needed PROGRAM NAME: ADDRESS: PHONE NUMBER: DATE OF BIRTH: GENDER: CHILD'S FULL NAME: PHOTO OF PREFERRED NAME/NICKNAME: CHILD (Optional) CHILD'S HOME ADDRESS: NAME OF PERSON ENROLLING CHILD: RELATIONSHIP TO CHILD: ☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative ☐ Other PHONE NUMBER(S) OF PERSON ENROLLING CHILD: ADDRESS OF PERSON ENROLLING CHILD (IF DIFFERENT THAN CHILD): ok to text ) **EMAIL ADDRESS:** Authorized to **EMERGENCY CONTACT NAMES / ADDRESSES** PRIMARY PHONE NUMBER OTHER PHONE NUMBER / EMAIL Pick Up Child PRIMARY CONTACT: ☐ Yes ☐ No NF0 ☐ ok to text ok to text **EMERGENCY** ) ) □ Yes □ No ok to text ok to text ) ) ☐ Yes ☐ No ok to text 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: ■ None ☐ Occupational Therapy ☐ Early Intervention/Special Education ☐ Speech/Language ☐ Physical Therapy ☐ Allergies (Please list) 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: ( ) -PHONE NUMBER: CHILD'S DENTAL CARE: **AGREEMENTS** • I consent for my child to take part in neighborhood trips (i.e., library, park and playground) away from the program • I understand the program may need additional permissions for situations such as transportation, medication, • I provided information on my child's special needs to the program to assist in caring for my child...... • I understand the program must give parents, at the time of enrollment of a child, a written policy statement as

I agree to review and update this information whenever a change occurs and at least once every year...... □ Yes □ No

DATE:

SIGNATURE - PARENT OR PERSON(S) LEGALLY RESPONSIBLE: