THE H.E.S. AFTER-SCHOOL PROGRAM PARENT HANDBOOK
The H.E.S. Child Care Membership

Parent/Guardian Information
Email: ____________________________

First Name: ___________________ Last Name: ___________________
Gender: ___________________ DOB: ___________________ Phone: ___________________
Address: ___________________ Apt/Fl: ___________________
City: ___________________ State: ___________________ Zip Code: ___________________

Participant Information
First Name: ___________________ Last Name: ___________________
Gender: ___________________ DOB: ___________________ Role: Participant

Authorized Pick-up and Emergency Contact Information

| Full Name: ___________________ Relationship: ___________________ |
| Role: Emergency Contact | Pick-up | Cell Phone Number: ___________________ |
| ___________________ Relationship: ___________________ |

| Full Name: ___________________ Relationship: ___________________ |
| Role: Emergency Contact | Pick-up | Cell Phone Number: ___________________ |
| ___________________ Relationship: ___________________ |

| Full Name: ___________________ Relationship: ___________________ |
| Role: Emergency Contact | Pick-up | Cell Phone Number: ___________________ |
| ___________________ Relationship: ___________________ |

Child Care Program (Please Circle Program) - Vacation Program Y/N _ Extended Day Y/N _
Public School ASP | Charter School ASP | Learning Lab | Other ____________

Billing Type (Please Circle)
Private Pay | Voucher | Other
Billing Cycle (Please Circle)
Weekly | Bi-Weekly | Monthly | Other

Payment Method (Circle One):
Bank Draft (attach voided check) | Credit Card (enter below)
Name on Card: ___________________ Card Number: ___________________
Expiration Date: ___________________ Card Type: ___________________
Address: ___________________

I hereby authorize the Hebrew Educational Society to bill the above payment method at
the specified billing type above and agree to all draft policies.

Full Name: ___________________ Signature: ___________________
Total Fee: ___________________ Date: ___________________
Billing Amount: ___________________ Start Date: ___________________ End Date: ___________________

FOR OFFICE USE ONLY
Amount Paid _______________ Receipt Number _______________ Starting Date _______________
Fee Amount _______________ Pro Rate _______________
Application Accepted By: ___________________
Supervisor’s Signature: ___________________

HEBREW EDUCATIONAL SOCIETY
9502 SEA VIEW AVENUE, BROOKLYN, NEW YORK 11236
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 Hebrew Educational Society  2020-2021

CHILD'S LAST NAME_________________________  FIRST NAME ___________________________  M ☐ F ☐

Home Address: ____________________________ Phone: ________________________________

Parent or Guardian: _________________________ Phone: ________________________________

Place of Employment: Father (Guardian) __________ Phone: ______________________________
Mother (Guardian) __________________________ Phone: ________________________________

In case of emergency, notify: ______________________________________________________

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 allergies; give appropriate dates)

□ Rheumatic Fever __________________________ □ Hay Fever ___________________________
□ Seizures _________________________________ □ Poison Ivy, etc. _______________________
□ Diabetes _______________________________ □ Insect Stings __________________________
□ Asthma _________________________________ □ Penicillin ____________________________
□ Chicken Pox ____________________________ □ Other Drugs __________________________
□ Food ___________________________________ □ Other ________________________________

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
Hebrew Educational Society
9502 Seaview Avenue
Brooklyn, New York  11236
**TO BE COMPLETED BY THE PARENT OR GUARDIAN**

**CHILD & ADOLESCENT HEALTH EXAMINATION FORM**

**NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION**

**Health Insurance**
- Yes
- No

**Other Details**
- Foster Parent

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**TO BE COMPLETED BY THE HEALTH CARE PROVIDER**

**Medical History**
- Yes
- No

**Physician**
- Name
- Address

**Immunizations**
- Date
- Provider

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**IMMUNIZATIONS**

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<thead>
<tr>
<th>Immunization</th>
<th>Date</th>
<th>Provider</th>
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**Health Care Practitioner Signatures**

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**Health Care Practitioner Name and Degree**

**Address**
- City
- State
- Zip

**Telephone**
- Phone

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**Health Care Practitioner Signatures**

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**Health Care Practitioner Name and Degree**

**Address**
- City
- State
- Zip

**Telephone**
- Phone
PARENT TO CHILD’S TEACHER PERMISSION LETTER

Dear Sir or Madam,

This is to inform you that my child, 
______________________________ of class _______ will be attending the After School Program at the Hebrew Educational Society for the 2020-2021 school term. Please dismiss this child with the regular bus children at the end of the school day to the H.E.S. bus counselor.

Thank you for your attention to this matter. If you have any questions, please call the H.E.S. at 718-241-3000 and ask for our After School Program Staff.

Parent’s Signature: ________________________________
Date: ____________________
PARENT TO SCHOOL OFFICE PERMISSION LETTER

Dear Sir or Madam,

This is to inform you that my child, 
__________________________ of class _________ will be attending the After School Program at the Hebrew Educational Society for the 2020-2021 school term. Please dismiss this child with the regular bus children at the end of the school day to the H.E.S. bus counselor.

Thank you for your attention to this matter. If you have any questions, please call the H.E.S. at 718-241-3000 and ask for our After School Program Staff.

Parent’s Signature: ____________________________
Date: ____________________________
NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD CARE EMPLOYEE, VOLUNTEER, PARENT, CHILD AND ESSENTIAL VISITORS
HEALTH SCREENING ONE-TIME ATTESTATION

Before entering a child care program, employees, volunteers, parents, children and essential visitors must complete a health screening questionnaire daily. In addition, each employee, volunteer, parent, child and essential visitor must sign and submit this form to the program one time. Employees, volunteers, parents, children and essential visitors must answer all questions and take their temperature daily to confirm a body temperature lower than 100.0 degrees Fahrenheit. If anyone answers “Yes” to any of the questions below, they cannot enter the child care program. A parent or guardian is responsible for completing daily screening on behalf of their child(ren).

Self-Screening:

Below are the self-screening questions that employees, volunteers, parents, children and essential visitors are required to answer daily. If any of the answers to the below questions are “Yes,” individuals cannot enter the program. If the answers are “No” to all the following questions, individuals may enter the program. If employees, volunteers, parents, children and essential visitors cannot take their temperature at home, but answer “No” to all other questions, they may report to the program to have their temperature taken on site.

1. Is your temperature higher than or equal to 100.0 degrees Fahrenheit?
2. Have you had any known contact with a person confirmed or suspected to have COVID-19 in the past 14 days?
3. Are you currently experiencing ANY of the following symptoms?
   o Cough (new or worsening)
   o Shortness of breath (new or worsening)
   o Trouble breathing (new or worsening)
   o Fever
   o Chills
   o Muscle pain (new or worsening)
   o Headache (new or worsening)
   o Sore throat (new or worsening)
   o New loss of taste
   o New loss of smell
4. Have you tested positive for COVID-19 through a diagnostic test in the past 14 days?

If you have answered “NO” to all questions, you have passed and may enter the program.

If you have answered “YES” to any question, you will not be allowed to enter the program.

Attestation: By signing this document, I agree that I will self-monitor these symptoms each day and report the outcome per the instructions above and will not enter any child care program if any of the above symptoms or conditions are present.

/ /
Signature

/ /
Date

/ /
Signature

Note: This document must be signed and returned to the program prior to entry. A signed copy needs to be provided only once. The child care program must retain a copy for their records.
Assumption of the Risk and Waiver of Liability
Relating to Coronavirus/COVID-19

The coronavirus (COVID-19), has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and can spread from person-to-person contact. The Hebrew Educational Society of Brooklyn has and will continue to use its best efforts to institute and implement preventative measures to reduce the spread of COVID-19; however, the Hebrew Educational Society of Brooklyn cannot guarantee that you or your child(ren) may not become infected, exposed or otherwise contract COVID-19 while attending, participating in or otherwise engaging in any activities at or in connection with the Hebrew Educational Society of Brooklyn.

By signing this waiver and release, I acknowledge and agree that I, on my behalf and on behalf of my children: a) understand the contagious nature of COVID-19; b) voluntarily assume the risk that me, my child(ren) or anyone for whom I may be responsible may become infected, exposed or otherwise contract COVID-19 while attending, participating in or otherwise engaging in any activities at or in connection with the Hebrew Educational Society of Brooklyn; and c) hereby waive, release and discharge the Hebrew Educational Society of Brooklyn from and against any and claims or injuries arising out of, relating to or in any way connected to COVID-19 and the subject of this Waiver and Release.

__________________________________________  __________________________________________
Name of Participant                                           Signature of Participant

________________________________________
Date

If you have a child under age 18 attending Hebrew Educational Society of Brooklyn for any purpose, please complete the following:

__________________________________________  __________________________________________
Name of Child                                           Signature of Parent/Legal Guardian

________________________________________
Date