THE H.E.S. SUMMER CAMP

HEBREW EDUCATIONAL SOCIETY

9502 Seaview Avenue, Brooklyn, NY 11236

THEHES.ORG | 718.241.3000

JUNE 28th - August 18th 2023

H.E.S. JCC
YOUR Community Center

PROUD PARTNER
UJA Federation NEW YORK

WHERE THERE IS A NEED, WE STAND READY TO SERVE

H.E.S. JCC

HEBREW EDUCATIONAL SOCIETY
9502 SEAVIEW AVENUE BROOKLYN, NEW YORK 11236
T: 718.241.3000 | F: 718.241.3349 THEHES.ORG

CAMP H.E.S. LETTER FROM THE DIRECTOR

Dear Parents or Guardians,

We would like to welcome you and your child(ren) to HES Summer Camp 2023. Listed below is important information regarding your child(ren)'s participation in summer camp. We look forward to providing your child(ren) with a safe and fun-filled summer!

SAFETY: The staff of the H.E.S. will provide your child(ren) with a fun-filled & safe summer camp experience. The H.E.S. Summer Camp is dedicated to ensure that your child's summer camp experience is fostered by our safety policies and procedures. The H.E.S. Summer Camp follows all DOH, CDC, City & State Guidelines

BUS PICK UP: Please be in front of your home or designated pick-up location approximately 10 minutes prior to your pickup time.

*****Please remember that the bus might be a few minutes late on the first few days of camp as we solidify our bus runs*****

BUS SERVICE: Please do not engage the driver or bus counselor in a lengthy conversation, as a few minutes lost at each stop can disrupt the entire bus schedule and delay the start of the camp day. If you have a message for your child's counselor, write a note and send it with your child or call the H.E.S. with your question or concern.

*****Please note; if your child takes the bus, and you need to take your child off the bus on a specific day/time, please notify the camp office by 7:00 AM for morning changes and 2:00 PM for afternoon changes otherwise arrangements cannot be made.***

WHAT TO SEND WITH YOUR CHILD: Everyday your children are in the building, regardless of the weather, pack 1 swimsuit, 1 towel and a plastic bag for the wet swimsuit in a comfortable backpack. This is necessary when the children are in the building. **All children MUST wear their camp tee-shirt on trip days; otherwise, they will not be permitted to attend the trip**.

Due to the Department of Health regulations, H.E.S. is not permitted to apply suntan lotion. If you would like your child to wear suntan lotion, please apply it at home or send your child with their own.

WRIST BANDS: At the beginning of the summer, each camper is given a wrist band to identify their swimming ability. The Department of Health requires that these wrist bands be worn every day. ***Do not remove the wrist band.*** They need to stay on for the entire summer.

BATHING CAPS: Children with long hair must bring bathing caps to wear in the pool every day. If they do not have a bathing cap, a bathing cap can be purchased for $5.00 at the camp.

BREAKFAST, LUNCH & AFTERNOON SNACK: Each child will be provided with a kosher breakfast and lunch. (A monthly menu will be provided.) In addition, an afternoon snack will be provided.

MEDICAL FORMS: MEDICALS MUST BE RETURNED BY JUNE 16, 2023. If the camp does not have a *current medical (*completed within the last year) by this date, your child will not be picked up or permitted to attend camp. Medicals must remain *current throughout the duration of camp.

TRIP CONSENT FORMS: **Pending City & State Guidelines** FORMS MUST BE SIGNED AND RETURNED before JUNE 16, 2023 in order for your child to start camp. These are consent forms for trips that may involve water activities and trips that do not involve water activities. The trips are subject to change.

CLOTHING: Each camper receives one free tee-shirt with the H.E.S. Camp Logo. No other uniform is required. **The H.E.S. tee-shirt must be worn on trip days. No child is allowed on a H.E.S. trip without a camp shirt. If your child does not have a camp shirt on, they must be picked up. Your child(ren) cannot remain in camp for the day, instead of going on the trip.** Additional H.E.S. tee shirts may be purchased for $10.00 each.

Parents are advised to send campers in comfortable inexpensive clothing. Depending on the weather, the children may wear shorts, slacks or jeans (dungarees). It is necessary for children to wear sneakers every day. No flip flops, open toe shoes or platform heels are permitted to be worn. ***There are no heelies (sneakers with wheels) allowed in camp.***

DO NOT SEND VALUABLE EQUIPMENT: Cell phones, cameras, video games, iPad, iPhone or iPods, mini disc players, etc., **MAY NOT** be brought to camp. The H.E.S. is not responsible for lost or damaged items. Label towels, swimsuits, clothing, etc., **with your child's name.**

Should your child lose any of their articles of clothing, they can be obtained, should they turn up, in the "LOST & FOUND". Please be sure to label, with your child's first and last name, each and every article of clothing you send with your child.

COMMUNICATION: During the summer, you can expect to receive camp updates regarding trips, special activities, and camp-wide programs. In addition, you will receive a monthly trip schedule, special days activity schedule and lunch menu. Be sure to ask your child for updates and notices on a daily basis.

Communication is a vital component to the success of the camp. Please keep program staff informed and up-to-date regarding any concerns, suggestions or recommendations.

*****Please note: If at any time you need to speak with your child, please feel free to call 718.241.3000 ext. 136.***

BEHAVIOR POLICY: Please see Camp H.E.S. behavior policy enclosed in this packet.

LEAVING CAMP EARLY: If you need to pick up your child before the end of the camp day, you must **call before 2:00 PM on that day**. **If campers are to leave camp before the end of the day, they must be signed out at the front desk with camp personnel.**

CAMP HOURS: Monday through Friday, 9:00 AM-4:30 PM excluding transportation, early-care, after-care, and extended day trips.

- SESSION I - June 28th - July 25th
- SESSION II - July 26th - August 18th
- FULL SEASON - June 28th - August 18th

NO CAMP Tuesday, July 4th, in observance of Independence Day!

MEDICAL ACCIDENT INSURANCE: The H.E.S. provides supplemental insurance for your child. There is a $25.00 deductible.

PROBLEMS: If there are any problems during the camp season, be sure to call the H.E.S. as soon as possible. If you want to leave a message, the camp office extension is 136.

H.E.S. Summer Camp is licensed by the New York City Department of Health and Mental Hygiene and is inspected twice yearly. The inspection reports are filed at the Bureau of Food Safety and Community Sanitation located at 253 Broadway 12th Floor, CN 59A New York, NY 10007.

Telephone: (212) 676-1600

Sincerely,

Steven Lebowitz
Camp Director

The H.E.S. Summer Camp Registration Form

Parent/Guardian Information

First Name: _____ Last Name: _____
Phone: _____ Email: _____
Address: _____ Apt/Fl: _____
City: _____ State: _____ Zip Code: _____

Participant Information

First Name: _____ Last Name: _____
Gender: _____ DOB: _____ Grade in the Fall: _____

Authorized Pick-up and Emergency Contact Information

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

Child Care Program (Please Circle)
Full Session Camp | Session 1 | Session2 | Camp Xtra | After Camp

Fee Category (Please Circle)
Private Pay | 11-99 | Voucher | Other _____

Fee Amount _____

Payments/Discounts _____

Consent for Emergency Medical Treatment and Transportation:

☐ *I hereby give authority to the Hebrew Educational Society Year-Round After School and Staff to obtain necessary emergency medical treatment for my child/ren with the understanding that the family will be notified as soon as possible.*

☐ *I give permission for my children to use the HES bus as transportation for the After-School and Camp programs.*

Signature: _____ Date: _____

H.E.S. JCC
YOUR Community Center!

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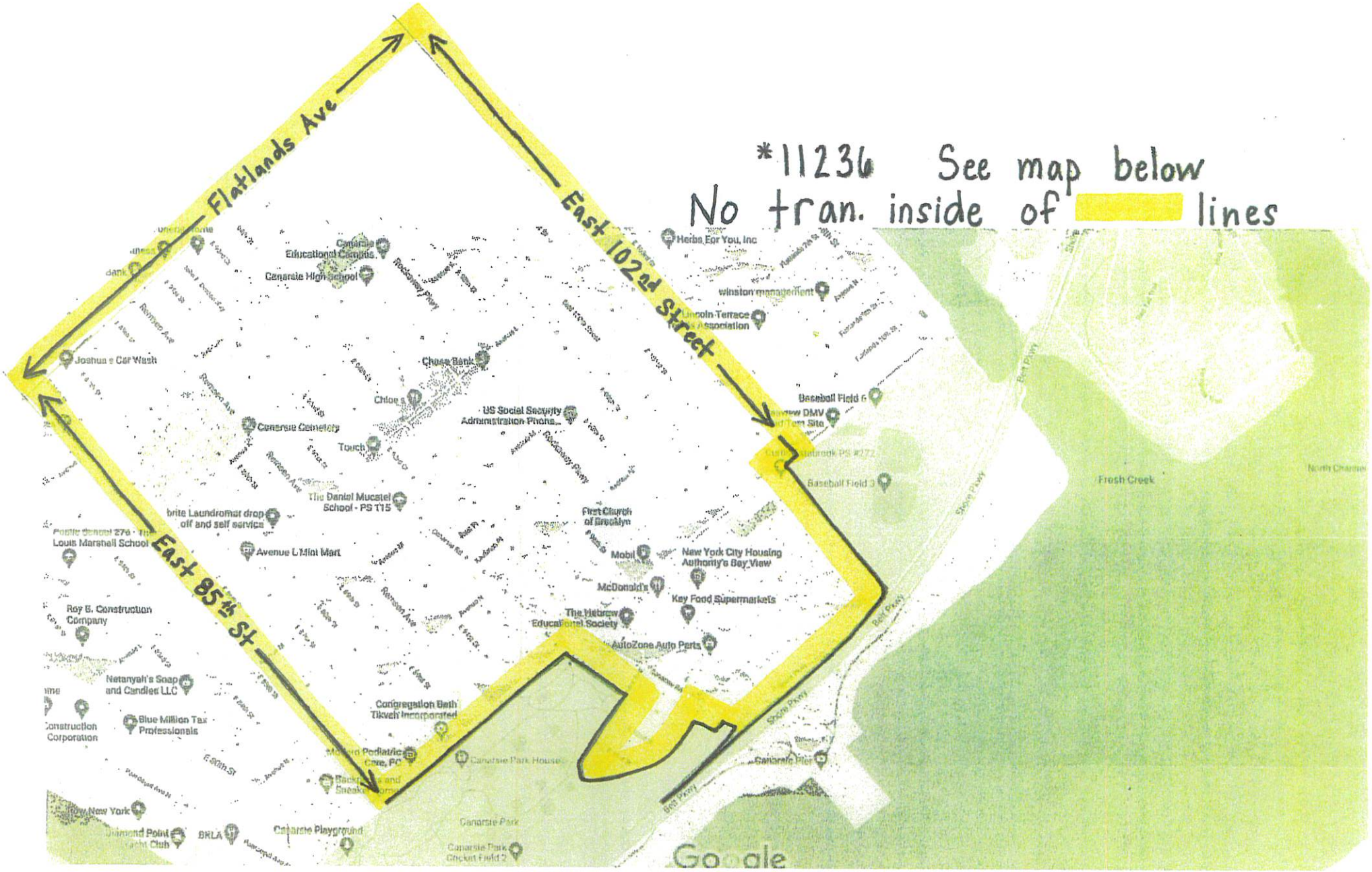
9502 SEAVIEW AVENUE, BROOKLYN, N.Y. 11236
WWW.THEHES.ORG | 718.241.3000

PROUD PARTNER UJA Federation NEW YORK

2023 Summer Camp 11236 Transportation Map

(No Transportation Provided within the highlighted area – This does not apply to 1199 participants)



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H.E.S. Summer Camp Transportation Request

Child's Name _____

Parent / Guardian's Name _____ Cell: _____

Bus Service Requested (Circle Applicable Times):

- AM
- PM
- AM & PM
- NONE

A.M. Bus Service (Pick-up)

____ My child will be taking the H.E.S. Summer Camp bus to the H.E.S. each morning

Address: _____ Zip: _____

____ Check here if the pick-up address is the same as the drop-off address

P.M. Bus Service (Drop-off)

____ My child will be taking the H.E.S. Summer Camp bus home each afternoon

Address: _____ Zip: _____

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TEEN CAMPERS ONLY

Parental Permission to Walk Home Form

I,_____ give my child, _____ permission to walk home alone from the H.E.S. Summer Camp without being signed out by a parent/guardian. I agree for this to be in effect from June 28, 2023 through August 18, 2023. I understand that my child will sign out from the H.E.S. Summer Camp at __:__ PM (4:30 PM-6:00 PM ONLY)

Parent's/Guardian's Name (Print) _____

Parent's/Guardian's signature: _____

Today's Date: _____

H.E.S. JCC

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The Hebrew Educational Society of Brooklyn is participating in the Summer Food Service Program. Meals will be provided to all eligible children free of charge. (To be eligible to receive free meals at a camp, children must meet the income guidelines for reduced price meals in the National School Lunch Program). Children who are part of households that receive food stamps or benefits under the Food Distribution Program on Indian Reservations (FDPIR), or Temporary Assistance to Needy Families (TANF) are automatically eligible to receive free meals. The following 2022-2023 income eligibility standards will be used for determining eligibility for free meals:

Income Eligibility Guidelines

Household Size	Year	Month	Twice Per Month	Every Two Weeks	Weekly
1	$25,142	$2,096	$1,048	$ 967	$484
2	$33,874	$2,823	$1,412	$1,303	$652
3	$42,606	$3,551	$1,776	$1,639	$820
4	$51,338	$4,279	$2,140	$1,975	$988
5	$60,070	$5,006	$2,503	$2,311	$1,156
6	$68,802	$5,734	$2,867	$2,647	$1,324
7	$77,534	$6,462	$3,231	$2,983	$1,492
8	$86,266	$7,189	$3,595	$3,318	$1,659
For each additional family member, add					
	$ 8,732	$ 728	$ 364	$ 336	$ 168

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

☐ Eligibility has been established for the site(s) listed. No further documentation is required.
☐ Please fill out and return an "Application for Free and Reduced Price School Meals/Milk."

Persons interested in receiving more information should contact: Moshit Rivkin, Hebrew Educational Society of Brooklyn, 9502 Seaview Avenue, Brooklyn, New York 11236, 718-241-3000.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7742; or

(3) email: program.intake@usda.gov

This institution is an equal opportunity provider.

Moshit Rivkin 2/6/2023

(Signature of Authorized Representative) (Date)

PROUD PARTNER
UJA Federation NEW YORK

Part 1. Children enrolled in Camp or Closed Enrolled Sites.

Names (First, Middle Initial, Last)	SNAP (Food Stamp), TANF or FDPIR case # (if any). **Skip to Part 4 if you listed a case #.**

Part 2. Foster Child

Foster children eligible for free and reduced-price meals regardless of household income. If a foster child lives with you, please contact **[name of Sponsor]** at **[phone number]**. Complete Part 3 if you are applying for other children in your household and you did not enter a SNAP (Food Stamp), TANF or FDPIR case number in Part 1.

Part 3. Total Household Gross Income—You must tell us how much and how often

A. Name (List **everyone** in household, including children)	**B. Gross income and how often it was received** *Example: $100/monthly $100/twice a month $100/every other week $100/weekly*				**C. Check if NO income**
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Social Security, pensions, retirement,	4. All Other Income	
1.	$____/____	$____/____	$____/____	$____/____	❑
2.	$____/____	$____/____	$____/____	$____/____	❑
3.	$____/____	$____/____	$____/____	$____/____	❑
4.	$____/____	$____/____	$____/____	$____/____	❑
5.	$____/____	$____/____	$____/____	$____/____	❑
6.	$____/____	$____/____	$____/____	$____/____	❑
7.	$____/____	$____/____	$____/____	$____/____	❑
8.	$____/____	$____/____	$____/____	$____/____	❑
9.	$____/____	$____/____	$____/____	$____/____	❑
10.	$____/____	$____/____	$____/____	$____/____	❑
11.	$____/____	$____/____	$____/____	$____/____	❑
12.	$____/____	$____/____	$____/____	$____/____	❑

Part 4. Signature and Social Security Number (Adult must sign)

An adult household member must sign this form. If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that this information is being given for the receipt of Federal funds. I understand that SFSP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: X_____ Print name:_____ Date: _____

Address:_____ Phone Number:_____

Last four digits of Social Security Number: __ __ __ __ ❑ I do not have a Social Security Number

Part 5. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ Asian ❑ White ❑ Black or African American	❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year

Household size: _____

Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free___ Reduced___ Denied___

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date: _____

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 of Brooklyn 2023-2024

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.# _____

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

DCR 7 (Rev. 2/04)

Hebrew Educational Society
9502 Seaview Avenue
Brooklyn, New York 11236

PHYSICAL EXAMINATION

(To be filled out by Physician – please note information on reverse side)

The purpose of this health record is to provide the staff with pertinent information which will help to serve the needs of this child in Day Camps and Afterschool and Youth Center programs.

IMMUNIZATION HISTORY – This is a record of dates of basic immunization and most recent booster doses.

DTaP, DTP, DT, Td	Date _____	Date _____	Date _____	Date _____	Date _____
Polio	Date _____	Date _____	Date _____	Date _____	Date _____
MMR	Date _____	Date _____	Date _____		
Hemophilus Influenzae type b (Hib)		Date _____	Date _____	Date _____	Date _____
Hepatitis B	Date _____	Date _____	Date _____	Date _____	
Varicella	Date _____	Date _____			
Pneumococcal Conjugate (PCV)	Date _____	Date _____	Date _____	Date _____	Date _____
Other ppd	Date _____	Other _____	Date _____	Other _____	Date _____

MEDICAL EXAMINATION – To be filled out by licensed physician.

Examination is acceptable when performed no more than 12 months prior to arrival at camp.

Code: S = Satisfactory
X = Not Satisfactory (Explain)
0 = Not Examined

General Appearance _____

Genitalia _____

Height _____ Weight _____ Blood Pressure _____ Posture & Spine _____ Throat - Tonsils _____

Nose _____ Teeth _____ Abdomen _____ Hernia _____ Feet _____ Lungs _____ Skin _____

Hgb. Test (Date) _____ Urinalysis (Date) _____

Eyes _____ Vision _____ w/Glasses _____ Extremities _____ Heart _____

Ears _____ Hearing _____

Neurological Findings _____

Describe Abnormal Findings and/or Handicapping Conditions _____

_____

Allergy: *(Please specify)* _____

Recommendations and restrictions while in camp:

Special Diet _____

Special Medicine (dose, route of administration, when should it be administered) _____

Is parent/guardian sending special medicine? _____

Activity Restrictions _____

Swimming _____ Diving _____

General Appraisal: _____

_____

_____

I have examined the person herein described, reviewed his/her health history and it is my opinion that he/she is physically able to engage in Day Camp/Year Round Afterschool and Youth Center activities, except as noted above.

_____ M.D.
EXAMINING PHYSICIAN (SIGNATURE)

_____
PHYSICIAN'S NAME (PLEASE PRINT)

Telephone _____ Address _____

Date of Examination _____ _____
ZIP CODE

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 ☐☐☐☐☐☐☐☐☐

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

DOHMH ONLY **PROVIDER I.D.** ☐☐☐☐☐☐☐

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

Facility Name | National Provider Identifier (NPI)

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

Comments

Address | City | State | Zip

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

REVIEWER:

Telephone (____) ____-____ | Fax (____) ____-____

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