Cortelyou Early Childhood Center, Inc.

Main Office
1110 Cortelyou Road
Brooklyn, NY 11218
Phone: 718-282-6077
Fax: 718-282-2919

Annex
386 Marlborough Road
Brooklyn, NY 11226
Phone: 718-856-2880

Academy Building
2739 Bedford Avenue
Brooklyn, NY 11210
Phone: 718-421-9581
Fax: 718-421-2891

E-Mail: *info@mycecc.com* ***Website:*** *www.mycecc.com*

Pre-School Tuition & Fees 2024- 2025

Enrollment Fees

Enrollment and Textbook fees (*when applicable*) must be paid at the time of registration to secure your child's slot. This applies to all programs except certain 3-K and Pre-K for All programs. **These fees are paid annually, cannot be credited towards tuition payments and are non-refundable.** Please use this table at the bottom of this sheet to find the fees relevant for your program.

Tuition

Tuition is due on or before the fifth of each month. After the fifth, a late fee of $**50** will be added to your child's school fees. If school fees are not paid by the 15th of each month, we reserve the right to suspend your child's daycare service. If your child's service is suspended, there's a re-enrollment fee of $**100**. Please use the table below to identify your child's program fees.

Program	Hours of Operation	Enrollment Fee	Textbook Fee	Monthly Tuition
Nursery* **2 Years Old**	7:00am-6:00pm	$300	$0	$1,500
3-K & Pre-K for All **School Day ONLY**	3-K: 8:30am-2:50pm Pre-K: 8:00am-2:20pm	$0	$0	FREE
3-K & Pre-K for All **Extended Day**	3-K: 7:00am-6:00pm Pre-K: 7:00am-6:00pm	$200	3-K = $0 Pre-K = $115	3-K = $600 Pre-K = $500

*Our Nursery Program requires a down payment for the last month's tuition for your child (i.e. June 2025 for 2024-2025). The due date for this payment is one month from the date the application was submitted.

Parent Referral Program for Elementary School: Receive a $500 credit for each child you refer to our Elementary School program (K-5th Grade). A referral form **MUST** be timely filled out to be eligible to receive the credit. For more info, call us @ 718-282-6077 or 718-421-9581.

Updated as of **2/1/2024*

Cortelyou Early Childhood Centers, Inc.

Application for Admission (Toddlers – Fifth Grade)

Attach Child's Photo

Student Information Academic Year 2024-2025

First Name: _____ Last Name: _____ ☐ Male ☐ Female

Date of Birth _____ Place of Birth _____ Ethnicity: _____

Applicant for: **Pre-School** | 2's ☐ 3's ☐ **DOE** | 3-K for All ☐ Pre-K for All ☐ With Extended Day Services? ☐

Elementary School | Kdg. ☐ Gr. 1 ☐ Gr. 2 ☐ Gr. 3 ☐ Gr. 4 ☐ Gr. 5 ☐ What school district do you reside in?

- Does your child have an **IEP** (Individual Education Plan) or receiving any special services? ☐ Yes ☐ No

  If yes, please explain: _____

- Primary language(s) spoken at home: _____

Applicant's current/previous schools, if any:

Name	Address	Telephone

Parent/Guardian 1

Name: _____ Relationship to applicant _____

Address: _____ City _____ State _____ Zip_____

Contact Info: (H) _____ (C) _____ (W) _____

Email: _____ Occupation: _____

Employer: _____ Principal Contact: ☐ Both ☐ Mother ☐ Father

Parent/Guardian 2

Name: _____ Relationship to applicant _____

Address: _____ City _____ State _____ Zip_____

Contact Info: (H) _____ (C) _____ (W) _____

Email: _____ Occupation: _____

Employer: _____

Parent/Guardian Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic

If Parent/Guardian contact cannot be reached, whom do we contact in case of an emergency?

Name: _____ Contact Number: _____

Cortelyou Early Childhood Centers, Inc.

Name of person(s) authorized to pick-up your child: _____

List any food allergies, medical conditions, and/or dietary restrictions: (e.g. lactose intolerance, peanuts, Asthma, etc.)

_____

Is there anyone who is **NOT** allowed to have access to your child? (Please submit a copy of any supporting documentation.)

_____

Trip Consent Form

I hereby give permission to allow my child, _____ to be taken on trips to points of interest throughout the New York City area, under the supervision of **Cortelyou Early Childhood Center**, via private means of transportation. I also grant permission for my child to be taken on walking trips throughout the neighborhood when accompanied by his/her teacher.

(Initial Here: _____)

Photograph & Video Release

I hereby give permission for images of my child, captured during regular and special school activities through video, photo and digital camera, to be used solely for **Cortelyou Early Childhood Center** promotional material and publication including websites, brochure, handbooks etc., and waive any rights of compensation or ownership thereto. **(Initial Here: _____)**

CECC Special Needs Policy

At CECC, we recognize the right of each child, including those with special needs, to have an appropriate early childhood engagement, which combines care and learning through purposeful play. We are very sensitive to the needs and feelings of children with special needs, as well as, that of their families. We are committed to assist families to seek appropriate help, to ensure that their child' individual needs are recognized and addressed. Parents, we are aware that you are your child' primary advocate and that all decision making relating to him/her are in your hands. Therefore, parents will be involved at every stage in any plan that is recommended to support a child's individual special needs.

If any child in our school is having trouble with language or speech, vision, motor skills, social/emotional and cognitive skills; or adapting to the physical, social and behavioral environment of our program, we will try our best effort to connect the parents to appropriate agencies to conduct an early childhood evaluation.

However, if parents choose to decline an evaluation to assess the possible developmental needs their child may require, CECC reserve the rights to discontinue childcare services since we do not hold the necessary licensing and certification required to work with children requiring special services**. (Initial Here: _____)**

I have read the policy and agree to comply with the forms as stated.

Parent/Guardian 1 Signature: _____ Date: _____

Parent/Guardian 2 Signature: _____ Date: _____

OFFICIAL USE ONLY

☐ Accepted ☐ Not Accepted ☐ ACD ☐ HRA ☐ Co-Payment: $ _____ Weekly

☐ Registration Fee Paid ☐ Full Time ☐ Part-Time *** Grades 1-5 Only: Plan _____ Option _____**

Comments: _____ Date Rec'd _____ Rec'd by: _____

1110 Cortelyou Road Brooklyn, New York 11218 ▪ Phone (718) 282-6077 • Fax (718) 282-2919 ▪ www.mycecc.com

Cortelyou Early Childhood Center, Inc.

Parent Supplement for Day Care and Pre-School Students

Applicant's Name _____ Grade Applying to:

Parent(s) Name (s) _____, _____

How did you learn about Cortelyou Early Childhood Center and how do you see our program meeting your family's needs?

_____

_____

_____

Please tell us what you are looking for in a school.

_____

_____

_____

Are there any particular strengths or areas of concern that you would like to bring to our attention?

_____

_____

_____

What does your child enjoy doing? What is he/she like? Describe your child's social life (i.e. play dates, park, playground, family).

_____

_____

_____

Parent #1 Signature _____ Date _____

Parent #2 Signature _____ Date _____

1110 Cortelyou Road Brooklyn, New York 11218 ■ Phone (718) 282-6077 ■ Fax (718) 282-2919 ■ www.myceccc.com

CACFP
Child and Adult Care Food Program
New York State Department of Health

INCOME ELIGIBILITY APPLICATION for Child Care Centers

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME: Cortelyou Early Childhood Center

Print the name of the child(ren) enrolled in this child care center:

1. _____ 2. _____ 3. _____

DIRECTIONS:

Complete SECTION A if anyone in your household:

1. Receives Food Stamps
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR)
4. Currently has a foster child enrolled in day care

Complete SECTION B if SECTION A does not apply:

Sign, date and indicate the Social Security number of the adult signing the certification and return the completed form to the day care center.

SECTION A

Food Stamp Case Number _____

TANF Number _____

FDPIR Number _____

Foster Child's Name _____

Foster Child's Personal Monthly Income $ _____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true and correct and that all income is reported. I understand this information is being given for the receipt of Federal funds, that officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

Signature: _____

Date: _____

FOR SPONSOR USE ONLY

Sponsor Agreement Number 3409

Total Household Members _____

Total Income $_____

Free _____ Reduced _____ Paid _____

Signature of Determining Official _____

Date Determined ____ / ____ / ____

SECTION B

List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received **last month** in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, welfare payments, child support and any other sources of income.

Name of Household Members	Monthly Gross Income
1. _____	$ _____
2. _____	$ _____
3. _____	$ _____
4. _____	$ _____
5. _____	$ _____
6.	$

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true and correct and that all income is reported. I understand this information is being given for the receipt of Federal funds, that officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

Signature: _____

Print Name: _____

SS# - - Date:

CACFP
Child and Adult Care Food Program
New York State Department of Health

CACFP Agreement # **3409**

DAY CARE CENTER ENROLLMENT FORM

Center Name: **CORTELYOU EARLY CHILDHOOD CENTER**

Child's Name: _____

Male ☐ Female ☐ Date of Birth _____ Home Phone _____

Home Address _____

Mother/Guardian Name _____

Father/Guardian Name _____

Parent/Guardian Address and Phone, if different _____

In case of emergency, notify _____ Phone _____

Second person to notify _____ Phone _____

Physician's name _____ Phone _____

TIME MEALS SERVED

Breakfast 7:30 am to 8:30 am Lunch 11:30 am/pm and 12:30 pm Afternoon Snack 3 pm to 4 pm

If your child is in care during these times, he/she will receive the meal or snack that is being served.

What days will your child usually be at the center? M ☐ Tu ☐ W ☐ Th ☐ F ☐ Sat ___ Su ___

What hours will your child usually be at the center? Arrive _____ ☐ am ☐ pm

Depart _____ ☐ am ☐ pm

Signature of a parent/guardian _____ Date _____

❖ ❖ ❖ ❖

After 1 year of care

Is all the information above still correct? Yes _____ No _____

If no, what has changed? _____

Signature of a parent/guardian _____ Date _____

Section 9

Unless you list the Food Stamp, TANF or FDPIR number for the child or a household member or are applying for a foster child, Section 9 of the National School Lunch Act requires that you include the Social Security Number of the household member signing the application or indicate that the household member signing the application does not have a Social Security Number. You do not have to list a Social Security Number, but if a Social Security Number is not listed or an indication is not made that the adult household member signing the application does not have a Social Security Number, CACFP cannot approve the application. The Social Security Number may be used to verify the correctness of the information stated on the application. This may include program reviews, audits and investigations and may include contacting employers to determine income, contacting a Food Stamp, TANF or FDPIR office to determine current certification for Food Stamp, TANF or FDPIR benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims or legal actions if incorrect information is reported.

Definition of Income

Income means income before deductions for income taxes, social security taxes, insurance premiums, charitable contributions, and bonds, etc. It includes the following: (1) monetary compensation for services, including wages, salary, commissions or fees; (2) net income from non-farm self-employment; (3) net income from farm self-employment; (4) social security payments; (5) dividends or interest on savings or bonds, income from estates or trusts or net rental income; (6) public assistance or welfare payments; (7) unemployment compensation; (8) government civilian employee or military retirement, or pensions or veteran's payments; (9) private pensions or annuities; (10) alimony or child support payments; (11) regular contributions from persons not living in the household; (12) net royalties; (13) military benefits received in cash, such as housing allowance; and (14) any other cash income.

Definition of Household

Household means *family* as defined in Section 226.2. *Family* means a group of related or non-related individuals who are not residents of an institution or boarding house, but who are living as one economic unit.

INSTRUCTIONS FOR COMPLETING DOH-3688

Instructions for Parents or Guardians:

Write in the name of the child care center in the space provided.

Print the name of each child in your household who attends this child care center.

Section A: If anyone in your household receives Food Stamps, Temporary Assistance for Needy Families (TANF) or participates in the Food Distribution Program on Indian Reservations (FDPIR), complete Section A only. Write down the Food Stamp, TANF or FDPIR number (do not use your ACD or DSS child care subsidy number) and sign and date the form and return it to the day care center.

> **Foster children:** If your household includes a foster child who is in child care, complete Section A only. Write in the foster child's name and any income that the child receives from social services for his or her personal use. Write in *0* if the foster child does not receive any income. A separate application must be completed for each foster child. The foster parent or an official who represents the child must sign and date the form and then return it to the child care center.

Section B: Write in the names of all the people living in your household, even if they do not have any income. Include yourself and all other adults and children in the household, including unrelated people. Do not include the children in child care who are listed at the top of the form.

Enter the amount of income each person received **last month**, before taxes or anything else was taken out. Refer to the Definition of Income and the Definition of Household, above. If any amount last month was more or less than the usual, write in that person's usual income. The signature and Social Security Number of the adult signing the certification is required. If you do not have a Social Security Number, write *none*.

Instructions for Centers and Sponsors:

The *For Sponsor Use Only* section is to be completed, signed and dated by child care center or sponsor staff.

The sponsor/center representative must review the income eligibility application and ensure that it is completed as indicated in the instructions above. Then indicate the following:

The sponsor agreement number.

Total household members – This item does not have to be completed if the parent completed Section A. Add those indicated in Section B (if completed) to the children enrolled in child care.

Total Income – This item does not need to be completed if the parent completed Section A. Indicate the total monthly income as calculated from Section B. If the parent chooses not to disclose income, the application must be categorized as *paid*.

Free, Reduced or Paid – Compare the total household income and the total number of household members with the current year's Income Eligibility Guidelines (CACFP-3687) to determine if the household should be categorized as **Free, Reduced** or **Paid**. Use the appropriate column on the CACFP-3687 to categorize their income. For example, if the parent indicated biweekly income, multiply this amount by 26 to determine yearly income.

Incomplete applications (missing signatures, income information, or Food Stamp, TANF or FDPIR numbers) are categorized in the paid category.

The income eligibility application is valid until the last day of the month one calendar year from the date of submission. For example, a form submitted on May 12, 2010 is valid until May 31, 2011.

CENTER

NAME:

ADDRESS:

BORO: Brooklyn, NY

318K (REV. 8/02)

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BUREAU OF DAY CARE

DAY CARE CUMULATIVE HEALTH RECORD

Date of Admission _____

TO BE COMPLETED BY PARENTS/GUARDIANS AND DAY CARE STAFF

NAME: *(Last)*	*(First)*	*(Middle)*	SEX F ☐ M ☐	DATE OF BIRTH Country/State of Birth
ADDRESS: *(No.)*	*(Street)*	*(City/Boro)*	*(State)*	*(Zip)*
MOTHER'S NAME: *(First)* *(Last)*	FATHER'S NAME: *(First)*	*(Last)*	TELEPHONE NO Home: Work:	
FOSTER PARENT				
FOSTER AGENCY	ADDRESS		TELEPHONE #	
LANGUAGE SPOKEN IN HOME				

PERSON/S TO CONTACT IN CASE OF EMERGENCY *(Other Than Parent)*	
NAME	RELATIONSHIP TO CHILD
ADDRESS	TELEPHONE NO. Home: Work:

*NAME OF MEDICAL PROVIDER, CLINIC OR HOSPITAL

NAME	CONTACT PERSON	PATIENT NO.
ADDRESS		TELEPHONE NO.

SIGNIFICANT FAMILY HISTORY		IS CHILD ALLERGIC TO ANY:
( ) Sickle Cell	( ) Heart Disease	( ) Medications *(Specify)*
( ) Diabetes	( ) Hypertension	( ) None
( ) Convulsive Disorder	( ) Tuberculosis	( ) Foods *(Specify)*
( ) Allergies *(Specify)*	( ) Vision	( ) Insect Bites
( ) OTHER *(Specify)*	( ) Hearing	( ) OTHER

HOSPITALIZATIONS AND ILLNESSES	YES	NO	EXPLAIN
Has child ever been hospitalized or operated on?	☐	☐	
Has child ever had a serious accident (broken bone, head injury, fall, burns, poisoning)?	☐	☐	
Has child ever had a serious illness?	☐	☐	

SPECIAL HEALTH CONDITIONS (Long term or chronic)	AGE IT BEGAN	TREATMENT/MEDICATIONS
1.		
2.		
3.		
4.		
5.		

I, _____ hereby certify that information provided herein is complete and accurate.

CONSENT FOR EMERGENCY MEDICAL TREATMENT *(REQUIRED FOR ADMISSION TO DAY CARE)*

I do hereby give authority to the day care program staff to obtain necessary emergency medical treatment for my child, with the understanding that the family will be notified as soon as possible.

SIGNED _____ DATE _____ RELATIONSHIP _____

Subscribed and sworn to before me this _____ day of _____ 19 _____

_____ _____

Notary Public or Commissioner of Deeds (OPTIONAL) County of

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 ☐ 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 ______

Health insurance (including Medicaid)? ☐ Yes ☐ No	☐ Parent/Guardian ☐ Foster Parent	Last Name	First Name	Email	Cell ______ Work ______

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: ______ weeks gestation

☐ Complicated by ______

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* ______

☐ Foods *(list)* ______

☐ Other *(list)* ______

Attach MAF if in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma ***(check severity and attach MAF)***: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes ***(attach MAF)***
☐ Orthopedic injury/disability
Explain all checked items above.

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) ______
☐ ***Addendum attached.***

Medications ***(attach MAF if in-school medication needed)***
☐ None ☐ Yes *(list below)*

______

PHYSICAL EXAM **Date of Exam:** ___ /___ /___

Height ______ **cm** (___ ___ %ile)

Weight ______ **kg** (___ ___ %ile)

BMI ______ **kg/m²** (___ ___ %ile)

Head Circumference *(age ≤2 yrs)* ______ **cm** (___ ___ %ile)

Blood Pressure *(age ≥3 yrs)* ______ / ______

General Appearance:

☐ Physical Exam WNL

Nl Abnl	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*
☐ ☐ Psychosocial Development	☐ ☐ HEENT	☐ ☐ Lymph nodes	☐ ☐ Abdomen	☐ ☐ Skin
☐ ☐ Language	☐ ☐ Dental	☐ ☐ Lungs	☐ ☐ Genitourinary	☐ ☐ Neurological
☐ ☐ Behavioral	☐ ☐ Neck	☐ ☐ Cardiovascular	☐ ☐ Extremities	☐ ☐ Back/spine

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

Validated Screening Tool Used? Date Screened

☐ Yes ☐ No ____/____/____

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: ______

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< **1 year** ☐ Breastfed ☐ Formula ☐ Both

≥ **1 year** ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes *(list below)*

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
—— Child Care Only ——		
Hemoglobin or Hematocrit	____ /____ /____	______ g/dL ______ %

Hearing	*Date Done*	*Results*
< 4 years: gross hearing	____/____/____	☐*Nl* ☐*Abnl* ☐*Referred*
OAE	____/____/____	☐*Nl* ☐*Abnl* ☐*Referred*
≥ 4 yrs: pure tone audiometry	____/____/____	☐*Nl* ☐*Abnl* ☐*Referred*

Vision	*Date Done*	*Results*
<3 years: Vision appears:	____/____/____	☐ *Nl* ☐ *Abnl*
Acuity (required for new entrants and children age 3-7 years)	____/____/____	Right ______ /______ Left ______ /______ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental	
Visible Tooth Decay	☐ Yes ☐ No
Urgent need for dental referral *(pain, swelling, infection)*	☐ Yes ☐ No
Dental Visit within the past 12 months	☐ Yes ☐ No

CIR Number ☐☐☐☐☐☐☐☐☐☐

Physician Confirmed History of Varicella Infection ☐

Report only positive immunity:

IMMUNIZATIONS – DATES

DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Tdap	___/___/___	___/___/___		
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		MMR	___/___/___	___/___/___	___/___/___	
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Varicella	___/___/___	___/___/___	___/___/___	
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Mening ACWY	___/___/___	___/___/___	___/___/___	
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Hep A	___/___/___	___/___/___	___/___/___	
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Rotavirus	___/___/___	___/___/___	___/___/___	
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Mening B	___/___/___	___/___/___	___/___/___	
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Other ______	___/___/___	______	___/___/___	

IgG Titers	Date
Hepatitis B	___/___/___
Measles	___/___/___
Mumps	___/___/___
Rubella	___/___/___
Varicella	___/___/___
Polio 1	___/___/___
Polio 2	___/___/___
Polio 3	___/___/___

ASSESSMENT ☐ **Well Child** (Z00.129) ☐ **Diagnoses/Problems** *(list)* **ICD-10 Code**

______ ______

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions *(specify)* ______

Follow-up Needed ☐ No ☐ Yes, for ______ Appt. date: __ __ / __ __ / __ __

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other ______

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# ☐☐☐☐☐☐☐☐☐☐

OCFS-6040 (6/2020)

NEW YOK 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?
   - Cough (new or worsening)
   - Shortness of breath (new or worsening)
   - Trouble breathing (new or worsening)
   - Fever
   - Chills
   - Muscle pain (new or worsening)
   - Headache (new or worsening)
   - Sore throat (new or worsening)
   - New loss of taste
   - 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	Date

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.*