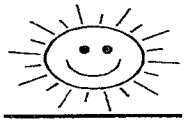


Emergency Contact Information

Date of Admission: _____ District: _____

Child's Name: _____
(First) (Middle) (Last)

Sex: F ☐ M ☐ Date of Birth: _____ Country/State of Birth: _____

Address: _____ Home #: _____
(Number) (Street) (Apt. #) (City/Boro) (State) (Zip Code)

Mother/Guardian: _____

Work #: _____ Cell #: _____ email: _____

Father/Guardian: _____

Work #: _____ Cell #: _____ email: _____

Language Spoken In Home: _____

FOSTER AGENCY INFORMATION

_____
(Foster Agency) (Address) (Telephone)

PERSON'S TO CONTACT IN CASE OF EMERGENCY (OTHER THAN PARENT)

1) _____ _____
(Name) (Relationship to Child)

Address: _____
(Number) (Street) (Apt. #) (City/Boro) (State) (Zip Code)

Home #: _____ Work #: _____ Cell #: _____

2) _____ _____
(Name) (Relationship to Child)

Address: _____
(Number) (Street) (Apt. #) (City/Boro) (State) (Zip Code)

Home #: _____ Work #: _____ Cell #: _____

3) _____ _____
(Name) (Relationship to Child)

Address: _____
(Number) (Street) (Apt. #) (City/Boro) (State) (Zip Code)

Home #: _____ Work #: _____ Cell #: _____

NAME OF MEDICAL PROVIDER, CLINIC OR HOSPITAL

Name: _____ Telephone #: _____

Address: _____
(Number) (Street) (Apt. #) (City/Boro) (State) (Zip Code)

Insurance: _____

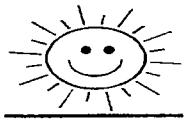
Chronic Diseases/Other Health Problems: _____

IS CHILD ALLERGIC TO ANY:

☐ None ☐ Foods (Specify): _____ ☐ Insect Bites: _____

☐ Medications (Specify): _____ ☐ Other: _____

PLEASE REMOVE AND SEND TO YOUR CHILD'S TEACHER



SIGNIFICANT FAMILY HISTORY

☐ Sickle Cell	☐ Heart Disease
☐ Diabetes	☐ Hypertension
☐ Convulsive Disorder	☐ Tuberculosis
☐ Allergies (Specify): _____	☐ Vision
☐Other (Specify): _____	☐ Hearing

Hospitalizations & 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	Age It Began	Treatment/Medications
(Long term or chronic)		
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

RELEASING CHILDREN AND ILLNESS

I understand and agree that in order to ensure the safety of all children; the school's policy is no child is to be released to anyone other than the child's parent/guardian. If I should need someone else to pick up my child at the bus stop or at school I will inform the school and bus company in advance and that person will have proper photo I.D. I also understand and agree that the school/bus company has every right to take my child to the local police precinct if no one is available to take my child.

Adults (18 years or older) authorized to pick up my child from the bus/school:

(1)_____ Relationship _____
(2)_____ Relationship _____
(3)_____ Relationship _____

PLEASE REMOVE AND SEND TO YOUR CHILD'S TEACHER

Sunshine Developmental School

91-10 146th Street

Jamaica, NY 11435

Tel 718-468-9000 Fax 718-464-2017

TOPICAL LOTION AND OINTMENT PERMISSION SLIP

Child's Name: _____

Teacher's Name: _____

_____ **I GIVE PERMISSION** to the staff at Sunshine School to apply over-the-counter topical ointments, including hand lotion, sunscreen and insect repellent to my child according to the instructions provided.

_____ **I DO NOT GIVE PERMISSION.**

Special Instructions:

_____

_____

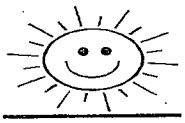
_____

_____

_____

_____ _____

Signature of Parent/Guardian Date



General Permission Slip

Child's Name _____ D. O. B. _____

Emergency Consent (Required for admission to Day Care)

In the event of a medical or school related emergency, I authorize the staff of Sunshine Developmental School to administer/initiate necessary medical intervention. I will also be immediately notified of the situation and will make myself available to pick up my child from school or meet the child at the hospital. I also give authorization for release of information to medical personnel (emergency contact, medical records, etc.)

_____ _____

Parent/Guardian Signature Date

Release of Information

I hereby give permission to Sunshine Developmental School to release/obtain information/reports to/from authorized personnel of the Board of Education. I understand that any exchange of records will be kept confidential.

_____ _____

Parent/Guardian Signature Date

Photographs/Videos

I authorize the staff of Sunshine Developmental School to photograph and videotape my child for educational purposes (name recognition, art projects, etc.), as well as an end of the year memory book/yearbook. Pictures and video tapes will not be released to any source outside of Sunshine Developmental School without specific instruction and parent authorization, including the internet (Facebook, My Space, etc).

_____ _____

Parent/Guardian Signature Date

Photographs/Videos

At times (i.e. birthday parties, graduation, etc) parents may wish to videotape or take photographs of the celebration. I give permission for my child's image to be included in these photos/videos. If I take photos/videos, I agree not to share them publicly, including not on the internet, including Facebook, My Space etc.

_____ _____

Parent/Guardian Signature Date

Walks and Trips

I authorize the staff of Sunshine Developmental School to take my child on walks in the community and neighborhood trips. I understand my child will be well supervised by certified personnel. Any distant field trip will require specific information and authorization by me.

_____ _____

Parent/Guardian Signature Date

PLEASE REMOVE AND SEND TO YOUR CHILD'S TEACHER

SUNSHINE
DEVELOPMENTAL
SCHOOL
91-10 146th Street
Jamaica, NY 11435
Tel: (718) 468-9000
Fax: (718) 464-2017
info@sunshineschool.org

Dear Parents &/or Guardians,

If your child is mandated to received Occupational Therapy (OT) and/or Physical Therapy (PT) on their IEP (*can be seen on the first page of their IEP*) please have their pediatrician fill out the following form labeled **"Order for School Health Related Support Services"** (found on the next page) so your child can begin receiving their services in our school. **They can fax it to (718)464-2017 ATTN: Leah Papantonis**

*It is important the doctor fills out the form completely

If you have any questions, please call:

Estimados Padres/Acudientes,

Si su hijo tiene el mandato para recibir terapia ocupacional (OT) y/o terapia física (PT) en su IEP (puede ser visto en la primera página de su IEP) por favor que su pediatra llene el siguente formulario llamado "Orden de Servicios de Salud Escolar Relacionados con Soporte" **("Order for School Health Related Support Services")**(*que se encuentra en la página siguiente*) para que su niño pueda comenzar a recibir sus servicios en nuestra escuela. PUede mandarlo por fax al (718)464-2017 ATTN: Leah Papantonis

*Es importante que el medico llene el formulario completamente

Si tiene alguna pregunta, por favor llame:

LEAH PAPANTONIS, MSPT

PT/OT Department Supervisor

(718) 468-9000 Ext.420

Fax: (718) 464-2017

Parental Consent Form for Physician Contact
(Re: Occupational Therapy and/or Physical Therapy Prescriptions)

I, _____, parent of
(Parent's Name)

_____ give Sunshine
(Child's Name)
Developmental School permission to send my child's Individualized Education Plan or OT/PT progress report to Sunshine's school doctor, Dr. Madeline R. Lalia and/or to my child's physician listed below,

Pediatrician's Name: _____

Address: _____

Phone #: _____

Fax #: _____

in order to facilitate the receipt of prescriptions for the recommendation of treatment in Occupational Therapy and/or Physical Therapy.

_____ _____

Parent Signature Date

Please return this form to Leah Papantonis

Doctor, Nurse Practitioner or Physician Assistant

Order for School Health Related Support Services

Student Name: _____ _____

First Last

Birth Date: ____/____/_____ **NYC Student ID:** _____

Month Day Year OSIS#

I have reviewed the recommendations on the student's IEP with respect to the therapies below and in my opinion, the following services are deemed medically necessary:

For each therapy on the student's IEP, mark one column and include ICD Code (s)

Please blacken a circle only for services on the IEP

	Service **IS** Medically Necessary	Service, as written, **IS NOT** Medically Necessary	**ID Code(s)** associated with each service
Occupational Therapy	◯	◯	
Physical Therapy	◯	◯	

_____ _____

Ordering Doctor, PA or NP's Signature (an original signature is required) Date

_____ _____

Ordering Doctor, PA or NP's Name Ordering Doctor, PA or NP's License Number

_____ _____

Address (Street) Ordering Doctor, PA or NP's NPI Number

_____ _____

Address (City, State, ZIP) Ordering Doctor, PA or NP's Medicaid Provider ID Number

_____

Telephone Number

Parental Consent Form for Hearing Screenings

As per the New York City Department of Health and Mental Hygiene, there are medical requirements for all students entering preschools. A complete physical examination **must** include a hearing screening. In order to comply with these regulations, the Speech-Language Therapy Department has implemented a hearing-screening program. This program will run throughout the year and it is only for students who are currently attending **Sunshine Developmental School.** You will receive the results of your child's hearing screening. We thank you for your cooperation.

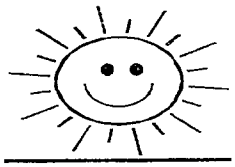
I, _____, parent of _____

(Parent's Name) (Child's Name)

(____give/____ not give) Sunshine Developmental School permission to screen my child's hearing.

_____ Date:_____

Parent/ Guardian Signature



Statement of Handbook Received

Child's Name: _____

I have read, understood and fully acknowledge and agree to follow what is stated in the Sunshine Developmental School's Parent Handbook.

_____ _____

Parent Signature Date

PLEASE REMOVE AND SEND TO YOUR CHILD'S TEACHER

Department of Education

REQUEST FOR CONSENT FOR MEDICAID REIMBURSEMENT

Dear Parent or Guardian,

I'm writing to ask for your assistance as we work to provide services for your child. Our schools can receive additional funding for some of the services that are provided to students, like your child, who have individualized education plans (IEPs). In order for our schools to receive this funding, we need your consent to (1) access and provide to the state and federal Medicaid programs personally identifiable information from your child's special education records about the special education evaluations, programs and services that are provided to your child and (2) access your child's Medicaid benefits to pay for these services. Please read the information below, complete the attached form and return it to your child's school.

Thank you for your assistance in ensuring that our public schools receive as much funding as possible for the critical supports that are provided to our students.

Sincerely,

Carmen Fariña
Chancellor

—

Why am I being asked to sign this consent form?

The New York City Department of Education (NYC DOE) uses Medicaid funding to help meet some of the costs of providing special education services to students. With your consent, the NYC DOE can submit claims for evaluations and services that are provided to your child. You are not required to sign up for Medicaid in order for your child to receive the services on his/her IEP.

What information about my child will be provided to state and federal Medicaid programs?

The NYC DOE will provide personally identifiable information about the special education evaluations and services provided to your child. This information may include the IEP, progress notes, attendance records, evaluations and other records and information about evaluations and services provided to your child.

Is there any cost to me or to my family?

There is no cost to you or your family. You will not be required to incur any expenses, premiums, costs or copayments for the provision of these services. The services that are provided to your child in and outside of school will not be affected in any way. If your family receives Medicaid benefits, your coverage will not be canceled, the lifetime coverage in place will not decrease and services that your family receives will not be affected in any way by the accessing of Medicaid benefits. You will not be required to sign up for or enroll in Medicaid for your child to receive the services on his/her IEP. You will not risk the loss of eligibility for home and community based waivers, if any, that are based on your total health-related expenditures.

Can I change my mind about allowing the NYC DOE to access my child's information and submit claims to the Medicaid program? What if I do not provide my consent?

You may change your mind about this consent at any time. To change your decision, complete a new form and send it to your child's school. The NYC DOE must still provide special education and services to your child at no cost to you even if you do not consent or you withdraw your consent at a later date.

Department of Education

CONSENT TO RELEASE INFORMATION FOR MEDICAID REIMBURSEMENT

Student's last name	*Student's first name*	*Date of birth*	*NYC Student ID*

Please select one choice below, sign and date the document, and return this form to your child's school.

○ Yes, I understand and agree that the NYC DOE may access my child's special education records, which may include the Individualized Education Program (IEP), progress notes, attendance records, evaluations and other records and information about services and evaluations that may be provided to my child and release this personally identifiable information to State and Federal Medicaid agencies as necessary to claim Medicaid reimbursement. I agree that the NYC DOE may access my child's Medicaid benefits to pay for special education and services provided as per my child's IEP.

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

○ No, I do not give permission for the NYC DOE to access my child's special education records to claim Medicaid reimbursement for special education services provided to my child.

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

CENTER

NAME:

ADDRESS:

BORO:

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