



Luria Academy- Kaitana

A Creative Summer Experience

Registration Form

Child's name: _____

Age: _____ DOB: _____ Gender: _____

Home Address: _____

Parent 1 Name: _____

Home Address: _____

Home: _____

Work: _____

Cell: _____

Email: _____

Parent 2 Name: _____

Home Address: _____

Home: _____

Work: _____

Cell: _____

Email: _____

Please indicate weeks attending:

Week 1 ___ 7/12-7/16 (\$450)	Toddler Half Day ___ (\$250)
Week 2 ___ 7/19-7/23 (\$450)	Toddler Half Day ___ (\$250)
Week 3 ___ 7/26-7/30 (\$450)	Toddler Half Day ___ (\$250)
Week 4 ___ 8/2 - 8/6 (\$450)	Toddler Half Day ___ (\$250)
Week 5 ___ 8/9 - 8/13 (\$450)	Toddler Half Day ___ (\$250)
Full 5 weeks ___ 7/12-8/13 (\$2000)	Toddler Half Day ___ (\$1000)

You may deduct 10% from the registration total if you are enrolling more than one child in the program.

Please indicate if sibling discount (10%) is being applied _____

Please indicate if you would be interested in a "Late Pickup" option _____

Please tell us how you heard about our program _____

Payment:

Check# _____ Amount \$ _____ Balance due \$ _____

Please make checks out to "Luria Academy of Brooklyn- Kaitana"

Credit Card:

Luria Academy Kaitana is pleased to offer you the option to have your tuition automatically charged to your credit card. Your credit card information will be kept completely confidential.

Credit Card Type: _____ Visa _____ Master Card _____ Amex

Cardholder (name as it appears on the card):

Credit Card Number:

Expiration Date: _____ / _____

Pin Number (3 numbers on the back of the card): _____

Credit Card Billing Address:

Number and Street Apartment

City

State

Postal Code

Signature of Card Holder

Date

Person(s) authorized to pick up child_____

Phone#(s)_____

Emergency Contact Name:_____

Relationship to Child:_____

Home Phone: _____ Work Phone_____

Cell Phone :_____ Email:_____

Doctor:_____

Address:_____

Phone:_____

Insurance Carrier:_____

Insurance Number:_____

Parent Signature: _____ Date _____

Please mail application to:

Natalie Benjamin
Director Luria Academy Kaitana
238 St. Marks Avenue
Brooklyn, NY 11238

Or email to: Natalie@luria-academy.org

All applications must be accompanied by a non-refundable deposit of \$200 - which will be applied toward the balance.

Balance and all medical forms due by June 28, 2010.

No child will be admitted without a current medical form- see attached.

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 <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (Month/Day/Year) ____/____/____
Child's Address			Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	Race (Check ALL that apply) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other
City/Borough	State	Zip Code	School/Center/Camp Name	District Number
Health insurance (including Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Parent/Guardian Last Name	First Name	Phone Numbers Home _____ Cell _____ Work _____	

TO BE COMPLETED BY HEALTH CARE PROVIDER *If "yes" to any item, please explain (attach addendum, if needed)*

Birth history (age 0-6 yrs) <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____ Allergies <input type="checkbox"/> None <input type="checkbox"/> Epi pen prescribed <input type="checkbox"/> Drugs (list) _____ <input type="checkbox"/> Foods (list) _____ <input type="checkbox"/> 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): <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent <i>If persistent, check all current medication(s):</i> <input type="checkbox"/> Inhaled corticosteroid <input type="checkbox"/> Other controller <input type="checkbox"/> Quick relief med <input type="checkbox"/> Oral steroid <input type="checkbox"/> None <input type="checkbox"/> Attention Deficit Hyperactivity Disorder <input type="checkbox"/> Orthopedic injury/disability <input type="checkbox"/> Chronic or recurrent otitis media <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Other (specify) _____	Medications (attach MAF if in-school medication needed) <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____ _____ Dietary Restrictions <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____ _____
--	---	---

Explain all checked items above or on addendum

PHYSICAL EXAMINATION Height _____ cm (____ %ile) Weight _____ kg (____ %ile) BMI _____ kg/m ² (____ %ile) Head Circumference (age ≤2 yrs) _____ cm (____ %ile) Blood Pressure (age ≥3 yrs) _____ / _____	General Appearance: <table border="0"> <tr> <td><i>Nl Abnl</i></td><td><input type="checkbox"/> HEENT</td><td><i>Nl Abnl</i></td><td><input type="checkbox"/> Lymph nodes</td><td><i>Nl Abnl</i></td><td><input type="checkbox"/> Abdomen</td><td><i>Nl Abnl</i></td><td><input type="checkbox"/> Skin</td><td><i>Nl Abnl</i></td><td><input type="checkbox"/> Psychosocial Development</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/> DENTAL</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Lungs</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Genitourinary</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Neurological</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Language</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/> Neck</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Cardiovascular</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Extremities</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Back/spine</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Behavioral</td> </tr> </table> Describe abnormalities: _____ _____	<i>Nl Abnl</i>	<input type="checkbox"/> HEENT	<i>Nl Abnl</i>	<input type="checkbox"/> Lymph nodes	<i>Nl Abnl</i>	<input type="checkbox"/> Abdomen	<i>Nl Abnl</i>	<input type="checkbox"/> Skin	<i>Nl Abnl</i>	<input type="checkbox"/> Psychosocial Development	<input type="checkbox"/>	<input type="checkbox"/> DENTAL	<input type="checkbox"/>	<input type="checkbox"/> Lungs	<input type="checkbox"/>	<input type="checkbox"/> Genitourinary	<input type="checkbox"/>	<input type="checkbox"/> Neurological	<input type="checkbox"/>	<input type="checkbox"/> Language	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/> Extremities	<input type="checkbox"/>	<input type="checkbox"/> Back/spine	<input type="checkbox"/>	<input type="checkbox"/> Behavioral
<i>Nl Abnl</i>	<input type="checkbox"/> HEENT	<i>Nl Abnl</i>	<input type="checkbox"/> Lymph nodes	<i>Nl Abnl</i>	<input type="checkbox"/> Abdomen	<i>Nl Abnl</i>	<input type="checkbox"/> Skin	<i>Nl Abnl</i>	<input type="checkbox"/> Psychosocial Development																						
<input type="checkbox"/>	<input type="checkbox"/> DENTAL	<input type="checkbox"/>	<input type="checkbox"/> Lungs	<input type="checkbox"/>	<input type="checkbox"/> Genitourinary	<input type="checkbox"/>	<input type="checkbox"/> Neurological	<input type="checkbox"/>	<input type="checkbox"/> Language																						
<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/> Extremities	<input type="checkbox"/>	<input type="checkbox"/> Back/spine	<input type="checkbox"/>	<input type="checkbox"/> Behavioral																						

DEVELOPMENTAL (age 0-6 yrs) <input type="checkbox"/> Within normal limits If delay suspected, specify below <input type="checkbox"/> Cognitive (e.g., play skills) _____ <input type="checkbox"/> Communication/Language _____ <input type="checkbox"/> Social/Emotional _____ <input type="checkbox"/> Adaptive/Self-Help _____ <input type="checkbox"/> Motor _____	SCREENING TESTS <table border="1"> <thead> <tr> <th></th> <th>Date Done</th> <th>Results</th> </tr> </thead> <tbody> <tr> <td>Blood Lead Level (BLL) <i>(required at age 1 yr and 2 yrs and for those at risk)</i></td> <td>____/____/____</td> <td>_____ µg/dL</td> </tr> <tr> <td>Lead Risk Assessment <i>(annually, age 6 mo-6 yrs)</i></td> <td>____/____/____</td> <td><input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk</td> </tr> <tr> <td>Hearing <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE</td> <td>____/____/____</td> <td><input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</td> </tr> <tr> <td>Hemoglobin or Hematocrit (age 9-12 mo)</td> <td>____/____/____</td> <td>_____ g/dL _____ %</td> </tr> </tbody> </table>		Date Done	Results	Blood Lead Level (BLL) <i>(required at age 1 yr and 2 yrs and for those at risk)</i>	____/____/____	_____ µg/dL	Lead Risk Assessment <i>(annually, age 6 mo-6 yrs)</i>	____/____/____	<input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk	Hearing <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE	____/____/____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Hemoglobin or Hematocrit (age 9-12 mo)	____/____/____	_____ g/dL _____ %	Tuberculosis <i>Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school</i> PPD/Mantoux placed _____/____/____ Induration _____ mm PPD/Mantoux read _____/____/____ <input type="checkbox"/> Neg <input type="checkbox"/> Pos Interferon Test _____/____/____ <input type="checkbox"/> Neg <input type="checkbox"/> Pos Chest x-ray (if PPD or Interferon positive) _____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Not Indicated <input type="checkbox"/> Abnl Vision <i>(required for new school entrants and children age 4-7 yrs)</i> _____/____/____ Acuity Right _____ / _____ _____/____/____ Left _____ / _____ <input type="checkbox"/> with glasses Strabismus <input type="checkbox"/> No <input type="checkbox"/> Yes
	Date Done	Results															
Blood Lead Level (BLL) <i>(required at age 1 yr and 2 yrs and for those at risk)</i>	____/____/____	_____ µg/dL															
Lead Risk Assessment <i>(annually, age 6 mo-6 yrs)</i>	____/____/____	<input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk															
Hearing <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE	____/____/____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal															
Hemoglobin or Hematocrit (age 9-12 mo)	____/____/____	_____ g/dL _____ %															

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 <input type="checkbox"/> Full physical activity <input type="checkbox"/> Full diet <input type="checkbox"/> Restrictions (specify) _____ Follow-up Needed <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____ Referral(s): <input type="checkbox"/> None <input type="checkbox"/> Early Intervention <input type="checkbox"/> Special Education <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____	ASSESSMENT <input type="checkbox"/> Well Child (V20.2) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-9 Code _____ _____ _____
--	---

Health Care Provider Signature	Date ____/____/____	DOHMH PROVIDER ONLY I.D. _____
Health Care Provider Name and Degree (print)	Provider License No. and State	TYPE OF EXAM: <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s)
Facility Name	National Provider Identifier (NPI)	Comments
Address	City	Date Reviewed: ____/____/____
Telephone (____) _____-____	Fax (____) _____-____	I.D. NUMBER _____
		REVIEWER: _____