

Office Use Only	
Date Application Received:	
Enrollment Start Date:	
Intake Specialist/Staff:	
Additional Information:	



## DYCD Universal Participant Intake: Youth & Adult Application

Welcome to the Department of Youth and Community Development (DYCD)! DYCD is a New York City agency that funds programs for youth and families. These programs are operated by Community Based Organizations (CBOs). This form will allow you or your child to apply to a DYCD Comprehensive Afterschool System (COMPASS), Beacon, or Cornerstone youth or adult program. Please complete this form fully and return to the CBO that operates the program. One application will be accepted per person per site. **Submission of an application does not guarantee enrollment in the program.** Further paperwork and information may be required to determine program eligibility. If accepted, program will be **at no cost** to the participant. The following application items are collected for informational and program planning purposes only: *Income, Gender, Race, Ethnicity, Language, Population Type, Household Information and Health Insurance Status.* Responses to these questions will not impact your eligibility to receive services and will not be shared outside of DYCD without the applicant's permission.

Part I: Applicant Information		
<p><b>For the purposes of this application, <i>applicant</i> refers to the person applying to receive services. Select one:</b></p> <p><input type="checkbox"/> I am completing this application for <u>myself</u></p> <p><input type="checkbox"/> I am a parent or guardian completing this application <u>for my child</u></p> <p><input type="checkbox"/> I am a relative/non-relative, completing this application <u>on behalf of the applicant</u></p>		
Applicant's First Name:	Applicant's Last Name:	MI:
Applicant's Date of Birth (MM/DD/YEAR):		
<p><b>Applicant's Gender (Select One):</b></p> <p><input type="checkbox"/> Male</p> <p><input type="checkbox"/> Female</p> <p><input type="checkbox"/> Gender Nonconforming</p>	<p><b>Applicant's Race (Select all that Apply):</b></p> <p><input type="checkbox"/> American Indian and Alaskan Native</p> <p><input type="checkbox"/> Asian</p> <p><input type="checkbox"/> Black or African- American</p> <p><input type="checkbox"/> Native Hawaiian and Other Pacific Islander</p> <p><input type="checkbox"/> White or Caucasian</p> <p><input type="checkbox"/> Other</p>	<p><b>Applicant's Ethnicity (Select One):</b></p> <p><input type="checkbox"/> Hispanic or Latino(a)</p> <p><input type="checkbox"/> Not Hispanic or Latino(a)</p>
Applicant's Primary Address (Number and Street):		Apt. Number:
City:		Zip Code:
<input type="checkbox"/> Applicant lives in a NYCHA Development (please provide name) _____		



### Part II: Contact Information

#### Applicant's Contact Information

For youth without contact information, skip to the next section to provide parent/guardian contact information

Write down phone numbers for the applicant and circle the preferred method of contact:

Home \_\_\_\_\_  Cell \_\_\_\_\_  
 Work \_\_\_\_\_  Email \_\_\_\_\_  No Email

#### Parent/Guardian Information

This section is required for Applicants under 18

Parent/Guardian Name: \_\_\_\_\_

Write down all phone numbers and circle the best number to call in case of an emergency:

Home \_\_\_\_\_  Cell \_\_\_\_\_  
 Work \_\_\_\_\_  Email \_\_\_\_\_  No Email

Address: <input type="checkbox"/> Same as Participant	City:	State:	Zip Code:
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#### Emergency Contact Information

At least one emergency contact must be identified

1	Emergency Contact #1 Name:	Relationship to Participant: <input type="checkbox"/> Emergency contact is parent/guardian of participant		
	Write down all phone numbers and circle the best number to call in case of an emergency:			
	<input type="checkbox"/> Home _____ <input type="checkbox"/> Cell _____ <input type="checkbox"/> Work _____ <input type="checkbox"/> Email _____ <input type="checkbox"/> No Email			
Address: <input type="checkbox"/> Same as Participant		City:	State:	Zip Code:
2	Emergency Contact #2 Name:	Relationship to Participant: <input type="checkbox"/> Emergency contact is parent/guardian of participant		
	Write down all phone numbers and circle the best number to call in case of an emergency:			
	<input type="checkbox"/> Home _____ <input type="checkbox"/> Cell _____ <input type="checkbox"/> Work _____ <input type="checkbox"/> Email _____ <input type="checkbox"/> No Email			
Address: <input type="checkbox"/> Same as Participant		City:	State:	Zip Code:



*This section is for parents/guardians enrolling their children*

*Emergency contacts listed in Section II are authorized to pick up the child unless otherwise noted.*

**The following additional people are authorized to pick up my child:**

**Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**The following people MAY NOT pick up my child:**

**Name:** \_\_\_\_\_ **Name:** \_\_\_\_\_ **Name:** \_\_\_\_\_

### Part III: Applicant's Education/Work Status

**Applicant's Education Status (Select One):**

- Full-Time Student\*\*\*     Part-Time Student\*\*\*     Not in School\*\*\*\*

\*\*\*If applicant is a *Part-Time Student* or *Full-Time Student*: **Select applicant's current grade (Select One):**

\*\*\*\*If applicant is *Not in School*: **Select the last grade completed by the applicant (Select One):**

**Elementary School:**     Pre-K     K     1<sup>st</sup>     2<sup>nd</sup>     3<sup>rd</sup>     4<sup>th</sup>     5<sup>th</sup>

**Middle School:**     6<sup>th</sup>     7<sup>th</sup>     8<sup>th</sup>

**High School:**     9<sup>th</sup>     10<sup>th</sup>     11<sup>th</sup>     12<sup>th</sup>

**Community College:**     1<sup>st</sup> year     2<sup>nd</sup> Year     3<sup>rd</sup> year     4<sup>th</sup> Year     5<sup>th</sup> year     6<sup>th</sup> Year+

**College/University:**     Freshman     Sophomore     Junior     Senior

**Other:**     High School Equivalence (HSE)     Vocational/Trade School     Foreign Degree

**Applicant's Current Work Status (Select One):**

- Employed Full-Time     Employed Part-Time     Retired  
 Unemployed (Short-Term, 6 months or less)     Unemployed (Long-term, more than 6 months)     Unemployed (Not in labor force)  
 Migrant Seasonal Farm Worker     Not applicable (applicant is under 14 years of age)

#### *Required for Full-Time Students*

**Student ID/ OSIS:**

**School Type:**

- Public     Charter     Private     Other \_\_\_\_\_

**School Name:**

**School Address:**

**City:**

**Zip Code:**



**Part IV: Health Information**

**Applicant's Health Information**

*Please answer the questions below and provide additional details in the space provided.  
Many needs or health challenges can be accommodated and may not limit enrollment in the program.*

**Does the applicant have any allergies? (food, medication, etc.)**

No  Yes \_\_\_\_\_

**Does the applicant have asthma?**

No  Yes

**Does the applicant have special health care needs?**

No  Yes \_\_\_\_\_

**Does the applicant take medication for any condition or illness?**

No  Yes \_\_\_\_\_

**Are there activities the applicant cannot participate in?**

No  Yes \_\_\_\_\_

**Please provide any additional health information details:**

N/A

**Please list any accommodation(s) you are requesting for yourself/the applicant:**

N/A

**Applicant's Health Insurance Status**

**Does the applicant have health insurance? (Select One):**

Yes  No  
 Decline to Answer

**If yes, what kind of health insurance does the applicant have? (Check all that Apply):**

Medicaid  Medicare  State Children's Health Insurance Program  
 Employment-Based  Direct-Purchase  State Children's Health Insurance for Adults  
 Military Health Care  Decline to Answer

**If you do not have health insurance, do you want to be contacted by someone else with information about signing up for public health insurance? (Select One):**

Yes  No  Decline to Answer

**If you would like to be contacted about signing up for public health insurance, what is your preferred method of contact? (Select One):**

Email  Phone  US Mail  Via provider  
 Decline to Answer

**Part V: Additional Applicant Information**

**How well does the applicant speak English?**  
(Select One):

- Fluent/Very well
- Well
- Not well
- Not well at all

**Applicant's Primary Language (Select One):**

- |   |  |                                   |
|---|--|-----------------------------------|
| <input type="checkbox"/> English        | <input type="checkbox"/> Albanian            | <input type="checkbox"/> Arabic   |
| <input type="checkbox"/> Bengali        | <input type="checkbox"/> Chinese*            | <input type="checkbox"/> French   |
| <input type="checkbox"/> Fulani         | <input type="checkbox"/> German              | <input type="checkbox"/> Gujarati |
| <input type="checkbox"/> Haitian Creole | <input type="checkbox"/> Hebrew              | <input type="checkbox"/> Hindi    |
| <input type="checkbox"/> Hungarian      | <input type="checkbox"/> Italian             | <input type="checkbox"/> Japanese |
| <input type="checkbox"/> Korean         | <input type="checkbox"/> Kru, Ibo, or Yoruba | <input type="checkbox"/> Mande    |
| <input type="checkbox"/> Punjabi        | <input type="checkbox"/> Persian             | <input type="checkbox"/> Polish   |
| <input type="checkbox"/> Portuguese     | <input type="checkbox"/> Romanian            | <input type="checkbox"/> Russian  |
| <input type="checkbox"/> Spanish        | <input type="checkbox"/> Tagalog             | <input type="checkbox"/> Turkish  |
| <input type="checkbox"/> Urdu           | <input type="checkbox"/> Vietnamese          | <input type="checkbox"/> Yiddish  |
| <input type="checkbox"/> Other: _____   |  |                                   |

*\*including Cantonese and Mandarin*

**Other Languages Spoken by Applicant (Select all that Apply):**

- |   |  |                                   |
|---|--|-----------------------------------|
| <input type="checkbox"/> English        | <input type="checkbox"/> Albanian            | <input type="checkbox"/> Arabic   |
| <input type="checkbox"/> Bengali        | <input type="checkbox"/> Chinese*            | <input type="checkbox"/> French   |
| <input type="checkbox"/> Fulani         | <input type="checkbox"/> German              | <input type="checkbox"/> Gujarati |
| <input type="checkbox"/> Haitian Creole | <input type="checkbox"/> Hebrew              | <input type="checkbox"/> Hindi    |
| <input type="checkbox"/> Hungarian      | <input type="checkbox"/> Italian             | <input type="checkbox"/> Japanese |
| <input type="checkbox"/> Korean         | <input type="checkbox"/> Kru, Ibo, or Yoruba | <input type="checkbox"/> Mande    |
| <input type="checkbox"/> Punjabi        | <input type="checkbox"/> Persian             | <input type="checkbox"/> Polish   |
| <input type="checkbox"/> Portuguese     | <input type="checkbox"/> Romanian            | <input type="checkbox"/> Russian  |
| <input type="checkbox"/> Spanish        | <input type="checkbox"/> Tagalog             | <input type="checkbox"/> Turkish  |
| <input type="checkbox"/> Urdu           | <input type="checkbox"/> Vietnamese          | <input type="checkbox"/> Yiddish  |
| <input type="checkbox"/> Other: _____   |  |                                   |

Not applicable (only one language spoken by applicant)

*\*including Cantonese and Mandarin*

**Would the applicant like to receive information/  
be contacted about registering to vote?\***  
(Select One):

- Yes  No

\*\*Applicant is eligible to vote in U.S. federal elections if:  
1) You are a U.S. citizen;  
2) You meet your state's residency requirements;  
3) You are 18 years old. Some states allow 17-year-olds to vote in primaries and/or register to vote if they will be 18 before the general election. Check your state's voter registration age requirements.

**Is the applicant any of the following:**

- |                                  |   |
|----------------------------------|---|
| Parent/Legal Guardian?           | <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| Offender/Justice Involved?       | <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| Foster Care Participant?         | <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| Runaway Youth?                   | <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| Veteran?                         | <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| Active Military Personnel?       | <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| An Individual with a Disability? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to answer |

**If the applicant is an individual with a disability, please select disability type(s)**  
(Select all that Apply):

- Cognitive impairment
- Hearing-related
- Learning disability
- Mental or Psychiatric
- Physical/Chronic Health Condition
- Physical/Mobility Impairment
- Vision-related
- Other: \_\_\_\_\_
- Decline to Answer

### Part VI: Household Information

For all the next set of questions, **HOUSEHOLD** is defined as any individual or group of individuals (family or non-family members) who are living together as one economic unit. **INCOME** is defined as the total annual gross income of all family and non-family members 18+years old living within the household.

**The applicant lives in a household that is headed by**  
(Select One):

- Single Parent - Female       Two Adults – No Children  
 Single Parent - Male       Two Parent Household  
 Single Person - No children     Multigenerational Household  
 Non-related adults with children       Other: \_\_\_\_\_

**Applicant's Housing Type (Select One):**

- Own       Rent       NYCHA  
 Shelter       Homeless  
 Other Permanent Housing  
 Other: \_\_\_\_\_

**Applicant's Household Size (Select One):**

- One       Two       Three  
 Four       Five       Six  
 Seven       Eight       Nine  
 Ten       Eleven       Twelve  
 Thirteen       Fourteen       Fifteen  
 Sixteen       Seventeen       Eighteen  
 Nineteen       Twenty+

**Total Household Income in the last 12 Months (Select One):**

- \$0       \$1 to \$12,060       \$12,061 to \$16,240  
 \$16,241 to \$20,420       \$20,421 to \$24,600       \$24,601 to \$28,780  
 \$28,781 to \$32,960       \$32,961 to \$37,140       \$37,141 to \$41,320  
 \$41,321 to \$50,000       \$50,001 to \$60,000       \$60,001 to \$70,000  
 \$70,001 to \$80,000       \$80,001 to \$90,000       \$90,001 to \$100,000  
 \$100,000+       Decline to Answer

**Sources of Applicant's Household Income (Select all that Apply):**

- Employment Wages       Affordable Care Act Subsidy       Alimony or other Spousal Support       Child Support  
 Childcare Voucher       Earned Income Tax Credit (EITC)       Employment Tax Credit       General Assistance  
 Housing Choice Voucher       HUD-VASH       LIEHEAP       Pension  
 Permanent Supportive Housing       Private Disability Insurance       Public Housing       Safety Net/Home Relief  
 Retirement Income from Social Security       Social Security Disability Income (SSDI)       Supplemental Security Income (SSI)       Supplemental Nutrition Assistance Program (SNAP)  
 Temporary Assistance for Needy Families (TANF)       Unemployment Insurance       VA Non-Service Connected Disability Pension       VA Service-Connected Disability Compensation  
 WIC       Worker's Compensation       Other: \_\_\_\_\_

Decline to Answer



**Part VII: Consents and Signatures**

**Pick-up/Dismissal Information**

*This question must be answered for parents/guardians enrolling their children*

**My child has permission to travel home alone at dismissal:**

Yes  No

**Consent to Participate**

To the best of my knowledge the information above is true. I agree to its verification and understand that falsification may be grounds for termination of service. Information provided may be used by the City of New York to improve City services and access to those services, and to access additional funding.

**If participant is 18 and over:**

I acknowledge that I am 18 years of age or older and am authorized to give consent.

Yes  No

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Participant: Print Name

\_\_\_\_\_  
Date

**If participant is under 18 years old:**

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Parent/Guardian: Print Name

\_\_\_\_\_  
Date

**Consent for Emergency Medical Treatment**

**If participant is 18 and over**

I am enrolled as a participant in a DYCD-funded program. In the event of a medical emergency, I hereby give consent for necessary emergency medical treatment to be obtained on my behalf. I further authorize the emergency contact(s) listed to be contacted.

Yes, I give my permission  No, I do not give permission

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Participant: Print Name

\_\_\_\_\_  
Date

**If participant is under 18 years old:**

My child is enrolled as a participant in a DYCD-funded program. In the event of a medical emergency, I hereby give consent for necessary emergency medical treatment for my child to be obtained, with the understanding that I will be notified as soon as possible. I understand that every effort will be made to contact me, or, if I am unavailable, the emergency contact(s) listed, before and after medical care is provided.

Yes, I give my permission  No, I do not give permission

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Parent/Guardian: Print Name

\_\_\_\_\_  
Date



**Consent for Photography/Videotaping and Use of Original Work**

As a participant enrolled in a DYCD-funded program, please be aware that from time to time DYCD and the City of New York, its contracted providers, authorized agents, third-party organizations with which it collaborates, or other government, representatives (collectively, "Authorized Parties") may be present during program activities and special events associated with program services, both at the usual program location and at off-site events. In some cases, they may photograph, videotape, interview or otherwise record participants and their families and friends in these programs. The resulting images, videos, and interviews may be used, with or without the participant's name, in printed and electronic media such as brochures, books, print and email newsletters, DVDs and videos, websites, social media and blogs (collectively, "Media").

I hereby authorize and permit the Authorized Parties, without compensation and without further approval, to photograph and/or record my and my child's image, name, likeness, and the sound of my and my child's voice during DYCD-funded program activities and special events, and I hereby consent to the resulting images, videos and interviews being used, without compensation and without further approval by the Authorized Parties solely for non-profit, non-commercial purposes in any and all Media.

Yes  No

If, in the course of participating in DYCD-funded program activities and special events, any original work such as art, music, choreography, poetry, or prose (collectively, "Original Work") is created by me or my child, I hereby consent to such Original Work being used by the Authorized Parties, without compensation and without further approval, solely for non-profit, non-commercial purposes in any and all Media.

Yes  No

**If participant is 18 and over:**

I acknowledge that I am 18 years of age or older and am authorized to give consent.

Yes  No

\_\_\_\_\_  
Full Name of Participant                      Participant's Signature                      Date

**If participant is under 18 years old:**

\_\_\_\_\_  
Full Name of Participant                      Parent/Guardian's Signature                      Date





**Parent/Guardian Consent to Collect and Share Student Information**

The **Department of Youth and Community Development (DYCD)** provides funding for this program as part of its mission to help you assist your child reach his or her full potential. Many of our programs are run by community based organizations. We work to make sure the services you and your children receive are of the highest quality. DYCD is requesting your permission to allow us to collect information we need on your child, their participation and the quality of the services provided.

**What information from your child's student records is DYCD requesting?**

We are requesting your permission for the **NYC Department of Education (DOE)** to share personally identifiable information from your child's student records with DYCD. The information we would like to collect consists of biographical and enrollment information (specifically consisting of your child's name, address, date of birth, student identification number, grade, school(s) attended and transfer, discharge, and graduation data about your child); data concerning your child's school attendance (including number of days attended and absences); and academic performance data (including your child's results on state and national exams, credits earned, grades, promotion and retention status, and fitnessgram score); and data related to any disciplinary actions taken against your child (including number and type of suspensions).

**We are requesting to collect the information listed above about your child on a past, present and future (i.e., ongoing) basis.**

We are also requesting your permission for DYCD to share information we collect on the enrollment form from you and/or your child with DOE staff. The information includes registration information, student's interests and challenges, type of program enrolled-in and frequency of participation. This information will be used to help the school and community organization work together to meet you and your child's needs.

**Who will see my child's information and how will it be safeguarded?**

The only people who will see your child's individual information are DYCD and DOE staff who manage the data systems and prepare research reports and program analyses. The limited number of DYCD staff identified to receive personal information is screened, and provided extensive training to follow strict guidelines on protecting the confidentiality of information that would personally identify you or your child. Personally identifiable information collected from student records will only be shared electronically between DOE and DYCD and will be secured and protected in the DYCD data base. Personally identifiable information will not be shared with any community based organizations or their staff members. We will not use your name or your child's name in any published report. While we request your consent, your responses to the below requests will not affect your child's participation in DYCD sponsored programs.

***Please check Yes or No to each of the following statements:***

I understand why DYCD is asking my permission to access the information listed above from my child's student records, and I give permission to DOE to share that information with DYCD on an ongoing basis.

**Yes, I give my permission**       **No, I do not give my permission**

I understand why DYCD is asking my permission to share information about my child collected by DYCD with DOE staff and I give my permission to DYCD to share information with DOE on an ongoing basis.

**Yes, I give my permission**       **No, I do not give my permission**

Student/Applicant Name: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Additional Parent/Guardian Name (optional): \_\_\_\_\_

Additional Parent/Guardian Signature (optional): \_\_\_\_\_



CBO: \_\_\_\_\_

School: \_\_\_\_\_

## Parent Consent for Participation in Afterschool Evaluation Data Collection (SONYC and COMPASS High Participants Only)

Dear Parent:

Your child is enrolled in an afterschool program that is supported by the Department of Youth and Community Development (DYCD). American Institutes for Research (AIR) is doing a study of the afterschool programs that are part of COMPASS. In order to monitor the effectiveness of these programs and ensure their future success, DYCD, and its evaluation partner AIR, are collecting information about participants and their experiences in the afterschool program, specifically around youth leadership development. This project has been approved by the Department of Education (DOE). AIR will visit some of the afterschool programs and survey its staff as well as youth and their families to learn more about DYCD afterschool programs and how they can be improved.

We ask permission from parents to conduct the following study activities:

- Administer 10-minute surveys to children asking about the DYCD afterschool program in which they participate and their perceptions of youth leadership development in the afterschool program
- Invite children to attend 45-minute focus group and/or interview about the DYCD afterschool program in which they participate, focused on their experience in the afterschool program and their perceptions of youth leadership development

AIR may also collect and analyze of your child's school records from New York City Department of Education, including demographic data, school day attendance, disciplinary referrals, grade promotion, and academic performance data (e.g., test scores and grades). These data are anonymous and completely confidential. The data will be combined to the school-level and we will not be able to link this school information to individual children or their families.

**Any information we collect will be used only to assess the DYCD afterschool program and will not be made public.** The only people who will have access to this information are members of the AIR evaluation team. Choosing not to participate in the evaluation will not affect your child in school, in the afterschool program, or in any other way. We will not use your name or your child's name in any report. There are no known risks to participating in this study. Participation is voluntary and participants may withdraw at any time. Please contact Jessica Newman by phone (312-588-7341) or email ([jnewman@air.org](mailto:jnewman@air.org)) with questions about the study.

If you have concerns or questions about your child's rights as a participant, please contact AIR's Institutional Review Board (which is responsible for the protection of project participants) at [IRB@air.org](mailto:IRB@air.org), toll free at 1-800-634-0797, or c/o IRB, 1000 Thomas Jefferson St. NW, Washington, DC 20007.

TURN THE PAGE TO COMPLETE AND SIGN →

## Parent Consent for Participation in Afterschool Evaluation Data Collection

Please select from the options below:

- Yes, I GIVE PERMISSION FOR MY CHILD, \_\_\_\_\_, TO PARTICIPATE IN THE FOLLOWING AIR DATA COLLECTION ACTIVITIES:*
- My child CAN complete AIR surveys about youth leadership development.*
  - My child CAN attend focus groups and interviews about their experience in the afterschool program and their perceptions of youth leadership development.*
  - Additionally, I would like to receive SMS text message updates about the evaluation of DYCD afterschool programs. AIR can send me text messages for future voluntary surveys. I understand that standard messaging may apply, and I can cancel at any time.*
- No, I DO NOT WANT MY CHILD, \_\_\_\_\_, TO PARTICIPATE IN THE AIR DATA COLLECTION ACTIVITIES.*

---

*Signature*

*Date*

### Consent for Audio Recording

If you gave your child permission to participate in focus groups and interviews, AIR researchers may record the student focus group and interviews for note-taking purposes. If you allow AIR to record the focus group and interviews, please sign below. No one outside of the research team will hear the recording, and the recording will be deleted when the study is concluded. Students can request to have the recorder turned off at any point.

- Yes, I allow my child to be audio-recorded in the focus groups and interviews.*
- No, I do not allow my child to be audio-record in the focus groups and interviews.*

---

*Signature*

*Date*

If you have any questions or concerns about the evaluation, please contact Jessica Newman, the project manager at AIR, at (312) 588-7341 or by email at [jnewman@air.org](mailto:jnewman@air.org). If you have questions about DYCD afterschool programs, visit DYCD Youth Connect <http://www1.nyc.gov/site/dycd/connected/youth-connect.page> or call by phone at 1-800-246-4646.

COMPASS PROGRAM

# 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 <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	Phone Numbers Home _____ Cell _____ Work _____	
Health Insurance (Including Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No		Parent/Guardian Last Name		First Name		Email		
		Foster Parent <input type="checkbox"/>						

## TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

<b>Birth history (age 0-6 yrs)</b> <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____		<b>Does the child/adolescent have a past or present medical history of the following?</b> <input type="checkbox"/> Asthma (check severity and attach MAF): <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent If persistent, check all current medication(s): <input type="checkbox"/> Quick Relief Medication <input type="checkbox"/> Inhaled Corticosteroid <input type="checkbox"/> Oral Steroid <input type="checkbox"/> Other Controller <input type="checkbox"/> None <b>Asthma Control Status</b> <input type="checkbox"/> Well-controlled <input type="checkbox"/> Poorly Controlled or Not Controlled	
<b>Allergies</b> <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) _____		<input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Behavioral/mental health disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Hospitalization <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Surgery <input type="checkbox"/> Orthopedic injury/disability <input type="checkbox"/> Other (specify) _____ Explain all checked items above. <input type="checkbox"/> Addendum attached.	
Attach MAF in in-school medications needed		<b>Medications</b> (attach MAF if in-school medication needed) <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)	

<b>PHYSICAL EXAM</b> Date of Exam: ____/____/____ Height _____ cm (____ %ile) Weight _____ kg (____ %ile) BMI _____ kg/m <sup>2</sup> (____ %ile) Head Circumference (age <2 yrs) _____ cm (____ %ile)		<b>General Appearance:</b> <input type="checkbox"/> Physical Exam WNL N Abnl <input type="checkbox"/> Psychosocial Development <input type="checkbox"/> HEENT <input type="checkbox"/> Lymph nodes <input type="checkbox"/> Abdomen <input type="checkbox"/> Skin <input type="checkbox"/> Language <input type="checkbox"/> Dental <input type="checkbox"/> Lungs <input type="checkbox"/> Genitourinary <input type="checkbox"/> Neurological <input type="checkbox"/> Behavioral <input type="checkbox"/> Neck <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Extremities <input type="checkbox"/> Back/spine	
<b>Blood Pressure (age &gt;3 yrs)</b> ____/____		<b>Describe abnormalities:</b>	

<b>DEVELOPMENTAL (age 0-6 yrs)</b> Validated Screening Tool Used? _____ Date Screened ____/____/____ <input type="checkbox"/> Yes <input type="checkbox"/> No Screening Results: <input type="checkbox"/> WNL <input type="checkbox"/> Delay or Concern Suspected/Confirmed (specify areas) below: <input type="checkbox"/> Cognitive/Problem Solving <input type="checkbox"/> Adaptive/Self-Help <input type="checkbox"/> Communication/Language <input type="checkbox"/> Gross Motor/Fine Motor <input type="checkbox"/> Social-Emotional or Personal-Social <input type="checkbox"/> Other Area of Concern: _____		<b>Nutrition</b> < 1 year <input type="checkbox"/> Breastfed <input type="checkbox"/> Formula <input type="checkbox"/> Both ≥ 1 year <input type="checkbox"/> Well-balanced <input type="checkbox"/> Needs guidance <input type="checkbox"/> Counseled <input type="checkbox"/> Referred <b>Dietary Restrictions</b> <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)		<b>Hearing</b> Date Done ____/____/____ Results < 4 years: gross hearing ____/____/____ <input type="checkbox"/> N <input type="checkbox"/> Abnl <input type="checkbox"/> Referred OAE ____/____/____ <input type="checkbox"/> N <input type="checkbox"/> Abnl <input type="checkbox"/> Referred ≥ 4 yrs: pure tone audiometry ____/____/____ <input type="checkbox"/> N <input type="checkbox"/> Abnl <input type="checkbox"/> Referred	
Describe Suspected Delay or Concern:		<b>SCREENING TESTS</b> Date Done Results <b>Blood Lead Level ( BLL )</b> (required at age 1 yr and 2 yrs and for those at risk) ____/____/____ _____ µg/dL ____/____/____ _____ µg/dL <b>Lead Risk Assessment</b> (annually, age 6 mo-6 yrs) <input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk		<b>Vision</b> Date Done Results <3 years: Vision appears: ____/____/____ <input type="checkbox"/> N <input type="checkbox"/> Abnl <b>Acuity (required for new entrants and children age 3-7 years)</b> Right ____/____/____ Left ____/____/____ <input type="checkbox"/> Unable to test Screened with Glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Strabismus? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Child Receives EI/CPSE/CSE services <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Hemoglobin or Hematocrit</b> _____ g/dL _____ %		<b>Dental</b> Visible Tooth Decay <input type="checkbox"/> Yes <input type="checkbox"/> No Urgent need for dental referral (pain, swelling, infection) <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Visit within the past 12 months <input type="checkbox"/> Yes <input type="checkbox"/> No	

CIR Number [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] Physician Confirmed History of Varicella Infection  Report only positive immunity:

<b>IMMUNIZATIONS - DATES</b> 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 _____	
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<b>ASSESSMENT</b> <input type="checkbox"/> Well Child (Z00.129) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-10 Code _____		<b>RECOMMENDATIONS</b> <input type="checkbox"/> Full physical activity <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"/> IEP <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____	
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Health Care Practitioner Signature		Date Form Completed ____/____/____		DOHMH ONLY PRACTITIONER I.D. [ ] [ ] [ ] [ ] [ ] [ ]	
Health Care Practitioner Name and Degree (print)		Practitioner 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 State Zip		Date Reviewed: ____/____/____ I.D. NUMBER [ ] [ ] [ ] [ ] [ ] [ ]	
Telephone		Fax		REVIEWER: _____	
		Email		FORM ID# [ ] [ ] [ ] [ ] [ ] [ ]	