After School Program Agreement Form

I, _____, parent/guardian of _____, agree to pay $_____ for my child's attendance at Steps To Success day care facility. ***__***I also understand that any deposits given to secure my child(ren)'s seat is non-refundable***__.

Please note there are no credits given for sick and/or vacation weeks in our After School Program. Please refer to price list for fees. In addition, Summer Program prices are different than our After School prices and vary depending on the amount of weeks a child will attend the Summer Program.

Steps To Success, LLC, and its agents reserve the right to terminate admission into said After School Facility if instances arise that can potentially be harmful or threatening to children attending the facility or staff/management performing their duties. Additionally, should a parent/guardian of an attending child constitute a threat, either mental or physical to any of the employees, management, or a child attending said After School Facility, management reserves the right to preclude admission.

Furthermore, if we are closed due to weather related conditions or events that are out of our control (i.e.: no electricity/heat, storm related disasters, floods) we are not liable and full tuition will be applied for that particular month ONLY. If we are closed due to any of the following unforeseen events below, in the first 5 days of closure, there will be no credit applied towards that month's tuition payment. In addition, we will *ONLY* provide credit for 50% of the remaining tuition paid for said month beyond the first 5 days. *If we are closed beyond that month, you will not be required to pay tuition until our centers re-open*:

1. Government forced shutdown
2. Department of Health Mandated Quarantine due to COVID cases
3. Pandemics
4. Force Majeure

PRICES ARE SUBJECT TO CHANGE

_____

Parent Signature

_____

Staff Signature

Mission Statement

At Steps to Success Preschool, we aim to promote our innovative and unique programs that strive to develop the highest quality experience for your children. Our goal is to educate our little student sin a loving and nurturing environment, to embody excellence in education, and to develop each child's social-emotional wellbeing. We accomplish this through fostering interaction with strong theoretical knowledge, and then facilitating experiential development as students put this knowledge into practice.

Your Child

Our Program

Their Success

Application for Admission

Child's Name: _____

Sex: _____ Date of Birth: _____

Toilet Trained: ☐ YES ☐ NO Scheduled Start Date: ____/____/____

Form of Deposit: ☐ Cash ☐ Credit Card ☐ Check #: _____

	Parent	Parent
Name:		
Home Address:		
City, State, Zip Code:		
Phone #:		
Cell #:		
***Email:		
*Emergency Pick Up Name/Information: Phone #:		

** In case of emergency, the above individual is authorized by the parent(s) to pick up a child. The authorized individual MUST show I.D. prior to child being released.*

Medical / Allergy Information

List All Allergies Below:	List Any Pertinent Medical Conditions:

Does your child have any specific needs that we need to know about?

How did you learn about Steps to Success ?

As a cooperative day care center, Steps to Success relies and respects parent involvement. How do you see yourself involved at our school?

Please list the 3 most important qualities you look for in a day care center:

1.

2.

3.

Parent Signature

Date

Price List

Full Time Program:	$1,100.00 per month
After School Program:	$600.00 per month - *from pick up - 7pm*
After School Program Full Days: ***This is for those children who are not enrolled in our After School program. If you are enrolled in our After School program, this does not apply to you.***	$75.00 per day

Note: Children that are not attending our day care program are classified as After School Children.

You are entitled to one (1) vacation week per year (5 consecutive days); where the weeks tuition is fully credited. You are entitled to two (2) sick weeks per year (5 consecutive days); where there is a 1/2 tuition credit issued for this week. Sick / Vacation time is considered 5 consecutive days when Steps to Success is open and operational, hence, this excludes holiday days or emergency closures.

*** Your year commences from the 1st day your child(ren) starts attending Steps to Success and you may NOT rollover any unused sick / vacation days into the following attending year.*

***** Any deposits given to secure a child's seat are non-refundable unless a 3 month notice prior to the start date is provided to Steps to Success.***

PRICES ARE SUBJECT TO CHANGE

Photo Release Form

Dear Families,

Steps to Success [Location] would like to request your permission in the use of your child's photo/picture for our facility's website and other forms of advertising.

Thank you,

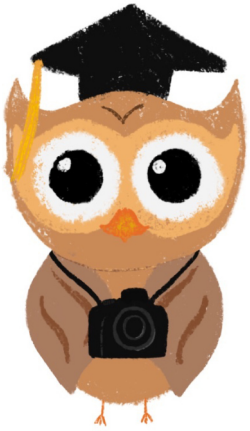
Management

◉ Yes, I agree to the terms above: _____

Parent Signature

○ No, I do not agree to the terms above: _____

Parent Signature



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 | Cell | Work

Health insurance (including Medicaid)? ☐ Yes ☐ No

☐ Parent/Guardian ☐ Foster Parent — Last Name | First Name

Email

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 in 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
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) _____
Explain all checked items above.
☐ *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

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

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

Validated Screening Tool Used? ☐ Yes ☐ No — Date Screened ___/___/___

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	___/___/___	☐ NI ☐ Abnl ☐ Referred
OAE	___/___/___	☐ NI ☐ Abnl ☐ Referred
≥ 4 yrs: pure tone audiometry	___/___/___	☐ NI ☐ Abnl ☐ Referred

Vision

	Date Done	Results
<3 years: Vision appears:	___/___/___	☐ NI ☐ 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#

CENTER

NAME:

ADDRESS:

BORO:

318K (REV. 4/12)

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BUREAU OF CHILD 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:
(____) Asthma	(____) 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.		

X 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

Pick Up Authorization

I (we), the parents of _____,
give my (our) consent for the following individual(s) to pick up my (our) child if I (we) are unable to do so.

Name:	Address:	Phone #:

The following individual(s) are not allowed to up my (our) child.

1. _____

2. _____

_____
Parent Signature:

_____
Provider Signature:

Permission for Outdoor Activities

The Provider, Steps to Success _____, and the staff of Steps to Success _____ may take my child _____ for any activities checked below as part of the Preschool Program:

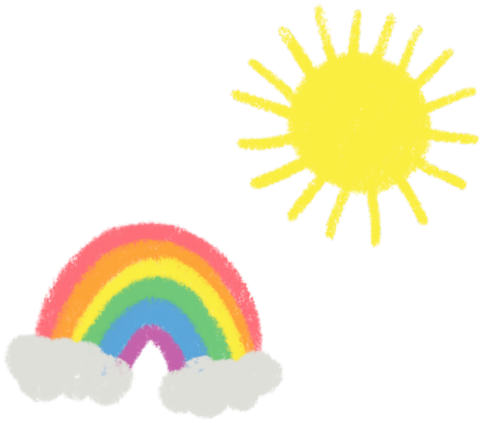
- ☐ On site playground
- ☐ Short walking trips

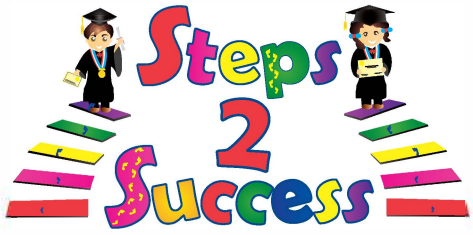
Parent Signature: _____

Address: _____

Phone Number: _____

Date: _____





To: School # _____

Class # _____

To Whom It May Concern:

I, _____, parent of

_____, am giving permission to Steps To

Success to pick up my child from school and return to their Afterschool Program.

If you have any questions, please contact me at: _____.

Thank you,

X _____ Date: _____

Signature of Parent/Guardian