Application For Admission

Child's Name:_____

Sex:_____ Date of Birth:_____

Toilet Trained: ☐ Yes ☐ No Scheduled Start Date:_____/_____/_____

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

Deposit Amount:_____

	Parent	Parent
Name:		
Home Address:		
City, State, Zip code:		
Occupation:		
Cell #		
Work #		
Email:		
*Emergency Pick up: Name/Information: Relation/Phone #		

*In case of emergency, the above individual is authorized by the parent(s) to pick up a child. The authorized individual **MUST** show ID prior to child being released and **MUST** be 18 years or older.

Medical / Allergy Information

List all Allergies below:	List any pertinent medical condition(s):

Do you have any concerns with any area of your child's development? Please use the space below to elaborate.

Describe any developmental evaluations / screenings done and subsequent approved services (Speech, OT, PT, SEIT) If your child has an IEP kindly attach it to this application.

Has your child previously attended Day Care?

☐ **Yes** ☐ **No**

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

1.

2.

3.

How did you learn about Steps to Success IV?

☐ **Google** ☐ **Facebook**

☐ **Instagram** ☐ **Family Friend – Name:**_____

☐ **Live Locally** ☐ **Other**

Parent Signature:_____ Date:_____

Program Agreement Form

I, _____, parent/guardian of _____,
agree to pay $_____ for my child's attendance at Steps To Success Daycare facility.

*** ***I also understand that any deposits given to secure my child(ren)'s seat is non-refundable unless a 3 month notice prior to the start date is provided to Steps To Success. Furthermore, should I decide to postpone my child's start date, I understand and acknowledge that a onetime allowance is permitted for a postponement and should we decide not to attend after the postponement is granted, our deposit is relinquished immediately as the 3 month notice policy will NOT apply (the 3 month refund policy ONLY applies to the initial start date selected).***

Payment is due by the 5th of each month or I am liable for $30.00 late fee. I understand that my child is permitted ONE (1) Vacation Week Credit (vacation time is considered 5 consecutive days and ***MAY*** include when Steps to Success is closed and non-operational for holidays or emergency closures) per year at no charge to me. In furtherance, I understand that my child is entitled to TWO (2) Sick Week Credits (5 consecutive school/OPERATIONAL days) per year for which I will be responsible for 50% of the tuition for that week ONLY. My year commences from the date that my child begins attending Steps to Success and will be construed as my official enrollment. I am aware that I may NOT rollover any unused sick / vacation days/credits into the following attending year. I am also aware that any credit for vacation or sick time is limited to ONLY ONE (1) week maximum per month. Sick / Vacation time is considered 5 consecutive days when Steps To Success is open and operational; hence, this excludes emergency closures. I am also aware that any credit for vacation or sick time is limited to ONLY ONE (1) week maximum per month.

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
3. Pandemics
4. Force Majeure

In addition, it is our policy that if you remove your child for a given month(s) you are responsible for half of the month's tuition in order to hold your child's seat. The maximum amount of days your child is permitted to attend within the month that you have notified management of non-attendance is five (5). If you go beyond the five permissible days, you will be responsible for the entire month's tuition less any applicable vacation/sick credits that you may have available and have not exhausted in the last 12 months. If your child is out for 2 consecutive weeks and we are unable to reach you and/or you have not contacted us, your child's seat is subject to being forfeited.

Finally, Steps To Success LLC, and its agents reserve the right to terminate admission into said Day Care Facility if instances arise that can potentially be harmful or threatening to children attending the facility and/or staff/management performing their duties. Moreover, 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 Day Care Facility, management reserves the right to preclude admission. Additionally, in the event that your child requires special needs care that we will unfortunately be unable and/or qualified to provide and once we have exhausted all options at our Center, for the betterment of your child's care and development, we will terminate services and assist in any way possible in finding alternate care.

PRICES ARE SUBJECT TO CHANGE

_____	_____	_____ / _____ / _____
Guardian Signature	Staff Signature	Date

OCFS-LDSS-0792 (08/2019) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DAY CARE ENROLLMENT

PHOTO OF CHILD (Optional)

PROGRAM NAME:	ADDRESS:	PHONE NUMBER: ( ) -
CHILD'S FULL NAME: PREFERRED NAME/NICKNAME:	DATE OF BIRTH: / /	GENDER:
CHILD'S HOME ADDRESS:		
NAME OF PERSON ENROLLING CHILD:	RELATIONSHIP TO CHILD: ☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative ____ ☐ Other ____	
PHONE NUMBER(S) OF PERSON ENROLLING CHILD: ( ) - ☐ ok to text EMAIL ADDRESS:	ADDRESS OF PERSON ENROLLING CHILD (IF DIFFERENT THAN CHILD):	

EMERGENCY INFO

EMERGENCY CONTACT NAMES / ADDRESSES	Authorized to Pick Up Child	PRIMARY PHONE NUMBER	OTHER PHONE NUMBER / EMAIL
PRIMARY CONTACT:	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text
	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text
	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text

FOR PROGRAM USE ONLY	*FOR PROGRAM USE ONLY*
DATE OF ENROLLMENT: / /	DATE OF DISENROLLMENT: / /

OCFS-LDSS-0792 (08/2019) REVERSE

CHILD'S FULL NAME:	DATE OF BIRTH: / /

Check boxes below to indicate if your child has any special needs/services: ☐ None

☐ Early Intervention/Special Education ☐ Occupational Therapy ☐ Speech/Language ☐ Physical Therapy

☐ Allergies (Please list) _____

☐ Other _____

Please provide information here **AND** discuss with your child care provider:

CHILD'S PRIMARY CARE PHYSICIAN'S NAME/ GROUP:	PHONE NUMBER: ( ) -
PREFERRED HOSPITAL:	PHONE NUMBER: ( ) -
CHILD'S DENTAL CARE:	PHONE NUMBER: ( ) -

Child health care information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: https://nystateofhealth.ny.gov/

AGREEMENTS

- I consent to emergency medical treatment for my child..... ☐ Yes ☐ No
- I consent for my child to take part in neighborhood trips (i.e., library, park and playground) away from the program under proper supervision..... ☐ Yes ☐ No
- I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips..... ☐ Yes ☐ No
- I provided information on my child's special needs to the program to assist in caring for my child..... ☐ Yes ☐ No
- I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation..... ☐ Yes ☐ No
- I agree to review and update this information whenever a change occurs and at least once every year..... ☐ Yes ☐ No

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:	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

Illness Protocol Guide

*Flu *Covid	1 week from start of symptoms **and** fever free with no medication for 48 hours
*Coxsackie	5-7 days from first symptom, fever free **and** sores/blisters are gone
*RSV	1 week from start of symptoms **and** fever free with no medication for48 hours cough has decreased in severity
Pink Eye	After 24 hrs of eye drops
*Stomach Virus	48 hours without vomiting or diaharrea
Strep Throat	24 hours after antibiotics **and** fever free for 24 hours
Random virus that causes a fever	Fever free for 48 hours without medication

***The chart above provides the minimum amount of time your child must remain at home. This is subject to increase based on the severity of the illness.

-You must visit the Doctor if your child is unwell for a diagnosis. It is important for the well-being of the center for us to know so that we may take the proper actions.

-If you notice that your child has green/yellow mucus you may be asked to keep them home for a day/two to monitor and ensure that a fever or other symptoms do not develop.

-It is upon management's discretion when your child may return to the center dependent on their diagnosis, not the doctor as they often send children back to school too soon. There are no exceptions to our 48-hour symptom free policy.

I have read and understood the illness policy set forth by Steps to Success IV.

Child's Name_____ Parent Signature_____

Date_____

Meal Check Off Form

Hours of Operation: 7am – 7pm

Dear Families,

Please check all the boxes that apply to your child in regard to the meals that you would like them to receive while under our care:

☐ AM Snack (Breakfast)	☐ Lunch	☐ Supper

Child's Name: _____

Parent/Guardian Signature: _____

Date: _____

NEW YORK STATE DEPARTMENT OF HEALTH
Child and Adult Care Food Program

Income Eligibility Form for Child Care Centers

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME _____

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

1. _____ 2. _____ 3. _____

Complete SECTION A if anyone in your household

1. Participates in the Supplemental Nutrition Assistance Program (SNAP)
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR) OR
4. Is a foster child

SECTION A

SNAP Case # _____

TANF # _____

FDPIR # _____

Names of Foster Children

_____

_____

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. I understand that the center will get Federal funds based on the information I give.

Signature _____

Date _____

FOR THE CHILDCARE CENTER TO COMPLETE

CACFP Agreement # _____

Total Number of Household Members _____
(INCLUDING FOSTER CHILDREN, IF APPLICABLE)

Total Household Income $ _____

Free _____ Reduced _____ Paid _____

Date of Determination _____

Signature of
Center Staff _____

Complete SECTION B if no one in your household participates in SNAP, receives TANF, participates in FDPIR or if none of the children enrolled in the child care center is a foster child.

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, child support, foster child's personal income and any other sources of income.

HOUSEHOLD MEMBER NAME	MONTHLY GROSS SALARY
1. _____	$ _____
2. _____	$ _____
3. _____	$ _____
4. _____	$ _____
5. _____	$ _____
6. _____	$ _____
7. _____	$ _____

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 that all income is reported. I understand that the center will receive Federal funds based on the information I give.

Signature _____

Print Name _____

LAST FOUR (4) DIGITS OF SOCIAL SECURITY NUMBER | | | | |

Date _____

This institution is an equal opportunity provider.

LATE PICK-UP POLICY

At Steps To Success, the safety and well being of all children in our care is our utmost priority. To maintain a structured environment for both staff and children, we have established the following Late Pickup Policy. Please read and sign this agreement to acknowledge your understanding and compliance with the outlined procedures.

Late Pick up Policy:

Designated Pickup Time: Our regular operating hours from September – June are 7AM – 7PM. Our summer hours for the months of July and August are 7:30AM – 6PM Monday – Thursday and 7:30AM – 5:30PM on Fridays. It is essential that children are picked up promptly at the end of each day.

Notification: If you anticipate being late, please notify Steps to Success as soon as possible . We understand that unforeseen circumstances can arise, and we appreciate your communication.

Emergency Contacts: If a child has not been picked up within ten minutes after closing time and we have not received any communication, our staff will begin contacting the emergency contacts listed in the child's file.

Repeated Offences: Persistent late pickups will be considered a breach of our agreement, and further actions will include a full day suspension for the following operational day. No credit will be provided for the suspension.

By signing below, I acknowledge that I have read, understood, and agree to adhere to the late Pickup Policy of Steps To Success. I understand the importance of timely pickups for the safety and well-being of all children and staff.

Print Name:_____

Signature:_____

Date:_____

Photo Release Form

Dear Families,

Steps to Success IV photographs children regularly for multiple purposes, such as:

To utilize for arts and crafts projects within the center.

To send parents photos via brightwheel of daily activities performing by the children (may be individual or group)

To post on social media forums such as our Facebook and Instagram accounts for advertising purposes.

Parents must grant Steps to Success IV permission, allowing photographs to be taken of a child for the above-mentioned uses.

Please select one of the following photo – permitting options below:

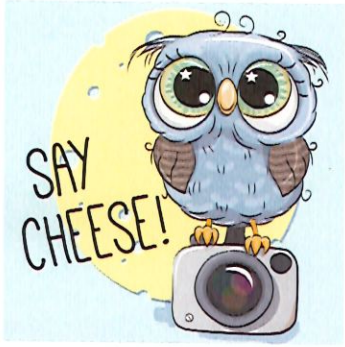
☐ **Option1:** I grant Steps to Success IV permission to photograph my child and to use those photos on social media, to send via brightwheel, to use for montages and to utilize for arts and crafts projects through out the center.

☐ **Option 2:** I grant Steps to Success IV permission to photograph my child and ONLY use those photos to send via brightwheel or for center-based projects.

Child's Name:_____

Parent Signature:_____

Date:_____



Pick Up Authorization

I _____, parent of _____ give consent for the following individual(s) to pick up my child if I am unable to do so.

Name:	Address:	Phone #:

The following individual(s) are not allowed to pick up my child:

Please note that if a parent is placed on the "no pickup list" proper legal documentation must be submitted to management.

1. _____

2. _____

3. _____

_____ _____

Parent Signature Date

_____ _____

Provider Signature Date

Permission for Outdoor Activities

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

- ☐ On site playground
- ☐ Fire Drills

Parent Signature: _____

Address: _____

Phone Number: _____

Date: _____

Parental Behavior and Termination of Enrollment

The well-being and safety of our staff and children are of paramount importance to us at Steps to Success. It is crucial for all members of our community to maintain a respectful, trusting and positive environment conducive to learning and growth.

Please be informed that the directors and management of Steps to Success reserve the right to terminate enrollment of any child due to the inappropriate behavior from guardians, rudeness, or harassment directed towards our staff or any member of our community. This includes, but is not limited to, demeaning remarks, threats, or excessive and unreasonable demands.

In situations where a parent or guardian exhibits such behavior, the daycare has the full authority to expel the child from our facility without any further discussions or inquiries. We appreciate your understanding and cooperation in upholding the values and standards of Steps to Success. Together, let us ensure a safe, nurturing, and respectful environment for all.

Print Name: _____

Signature: _____

Date: _____

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 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	☐ Seizure disorder	**Medications** ***(attach MAF if in-school medication needed)***
☐ Behavioral/mental health disorder	☐ Speech, hearing, or visual impairment	☐ None ☐ Yes *(list below)*
☐ Congenital or acquired heart disorder	☐ Tuberculosis *(latent infection or disease)*	
☐ Developmental/learning problem	☐ Hospitalization	
☐ Diabetes ***(attach MAF)***	☐ Surgery	
☐ Orthopedic injury/disability	☐ Other (specify) _____	
Explain all checked items above.	☐ ***Addendum attached.***	

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
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? ☐ 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	___/___/___	☐ 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

															IgG Titers	Date
DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___				Tdap	___/___/___	___/___/___			Hepatitis B	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___				MMR	___/___/___	___/___/___			Measles	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___				Varicella	___/___/___	___/___/___			Mumps	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___				Mening ACWY	___/___/___	___/___/___			Rubella	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___				Hep A	___/___/___	___/___/___			Varicella	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___				Rotavirus	___/___/___	___/___/___			Polio 1	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___				Mening B	___/___/___	___/___/___			Polio 2	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___				Other _____	___/___/___	_____ ___/___/___			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 ___/___/___

DOHMH ONLY PRACTITIONER I.D.

Health Care Practitioner Name and Degree *(print)*

Practitioner License No. and State

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Facility Name

National Provider Identifier (NPI)

Address City State Zip

Date Reviewed: ___/___/___

I.D. NUMBER

REVIEWER:

Telephone Fax Email

FORM ID#