SEND TO:

Fax:
212.931.8563

Email:
programs@theparrisfoundation.org

Call us:
1.800.STEM.414

S.T.E.M. CAMP & WEEKEND ENRICHMENT *APPLICATION*

Please provide student's information:

Student's Name: ________________________ **Current Grade**: _____ **DOB:** ___/___/___ **Gender:** M F

School Type: Public Private **School Name/Address:** ____

Please answer the following questions about your child (Answers will not affect participation):

1) What was your child's final **MATH** grade this year? (ex: 95 / Level 4): _______ / Level ______ (if applicable)

2) What was your child's final **SCIENCE** grade this year? (ex: 95 / Level 4): _______ / Level ______ (if applicable)

3) Does your child have **access to the INTERNET** at home? Yes No If yes, please circle all that apply:

   Desktop Laptop Tablet Smart Phone

4) I am enrolling my child for the following **Session(s)** and **Courses** (attending ALL is strongly encouraged)

Session 1: ***Spring*** (14 weeks Feb-May) **Session 2:** ***Summer*** (8 weeks July-Aug) **Session 3:** ***Fall*** (10 weeks Oct-Dec)

Parent/Guardian information:

Parent's Name: __________________________ **Email:** ______________________ **Add to mailing list?** Yes No

Address: ____ **Cell Phone #:** ____________________

I am interested in other FREE programs offered by The Parris Foundation (Tutoring, coaching, scholarships etc.). Therefore, I am willing to answer the following questions to help bring FREE programs to my community:

Please circle what best describes your child:

5) My child is a resident of Public Housing: Yes No (i.e. Carver, Polo Grounds etc.) If Yes, Name: _____________

6) My child **identifies** as:
   American Indian/Alaska Native Asian/Pacific Islander African-American/Black (Non-Hispanic)

   Hispanic White Other, Specify: __________________

7) My home has ____ parent(s) and there are ___(i.e. 3) people living in our home and our annual household **income** is:

Less than $25,000 $25,000 – $50,000 $50,000 – $75,000 $75,000+

10) My Child is eligible for the federal free lunch program: Yes No I'm not sure

Emergency Contact Information:

Contact's Name: _____________________________________ **Relationship:** ___________________________

Address: ____ **Cell Phone:** _____________________________

I ______________________________________, commit to bringing my child each week on Saturdays on time and expect my child to stay the duration of the program. I learned about your program from________________________

Parent/Guardian Signature: ______________________________________ **Date:** _____________

Student Agreement and Expectations

As a student, you can expect The Parris Foundation to provide:

- A comfortable, respectful and nurturing student working environment
- A clearly defined course curriculum with appropriate supervision, assistance and direction
- An assessment of your current skill-set to help provide the best learning tools for your personal needs
- Ability to learn at an individual pace and one-on-one instruction as required
- Eliminate *summer learning loss* of relevant core curriculum topics taught at your school *(summer only)*
- Fun and creative use of technology and interaction to keep you engaged
- A post curriculum assessment to determine your level of growth

As a student of The Parris Foundation, I agree to:

- Attend all schedule courses
- Comply with established practices of The Parris Foundation by behaving in an appropriate manner at all times
- Complete assignments as outlined in the student course description
- Take pride as a student participant and contribute to a mutually cooperative and supportive relationship with The Parris Foundation staff, community partners and volunteers
- Notify the Parris Foundation when sick or unable to attend (as soon as possible) and make up assignments before your next scheduled class

I have read and understand the above and agree to the terms. I further agree (by my signature) that I have been made aware of expectations set by The Parris Foundation.

______________________________________   ______________________________________

Student Name (Printed)   **Student Signature**

____

Date

______________________________________   ______________________________________

Parent/Guardian Name (Printed)   **Parent/Guardian Signature**

Official Use Only:
ID#: ______________
Loc: ______________

Sign-Out Authorization and Travel Alone Authorization

Student's Name: ________________________________ **DOB:** _____/_____/_____ Gender**:** M F

Parent/Guardian Name: ______________________________________

Parent/Guardian Phone: ______________________________________

☐ I authorize my child to sign in and out of The Parris Foundation programs on their own without my signature each week. A representative from The Parris Foundation will call me when my child is signing his/herself out.

☐ I authorize the following adults to sign my child in and out from The Parris Foundation programs without my signature each week. (Adults must show identification in order to sign out children).

Authorized Adult Names:

Name: ____ Phone: __________________________

Name: ____ Phone: __________________________

Name: ____ Phone: __________________________

Name: ____ Phone: __________________________

Parent/Guardian Signature: _____________________________ **Effective Date:** ________________________

This authorization will be in effect until is it signed by the Parent/Guardian as ineffective below.

Parent/Guardian Signature: __________________________________

Ineffective Date: ______________________

Official Use Only:
ID#: ______________
Name:____________
Sea Nut Glut Soy
Diary Vegan Veg
Pork Red Chk
Sug Carb Caff

S.T.E.M.ULATING *MINDS PROGRAM MEALS* FORM

Please provide student's information:

Student's Name: ____________________________ **Grade** (last completed): ____ **DOB:** ___/___/___ Gender**:** M F

Please answer the following questions about your child's **dietary restrictions**:

Please answer the following questions about your child's **dietary restrictions**:

1) Does your child have food allergies?: Yes No If yes, circle all that apply
   Shell Fish/Seafood Nuts Wheat/Gluten Soy Other, please specify: ___________
2) Does your child have lactose intolerances? (cannot have diary: milk, eggs, cheese, mayo) Yes No
3) Is your child a vegan? (no meat. no diary) Yes No
4) Is your child a vegetarian? (no meat. Diary ok) Yes No
5) Does your child have other dietary restrictions? Cannot have: Yes No If yes, circle all that apply
   Pork Red Meat Chicken Gluten
   High Fructose Carbonated Drinks Caffeine Drinks Other Specify_____________

Please circle session:
Fall ($50): 10 Weeks - Oct-Dec **Spring ($70):** 14 Weeks - Feb-May **Summer $40:** 8 Weeks - July-August

I _____________________________________, would like to provide a $5 per week donation to offset the cost of meals for my child for the duration of the 14 week program and I'm willing to make my donation of $50 for meals prior to the start or on the **1st day of the program.** My donation will be used to supplement the cost of ALL lunch meals and drinks on Saturday's during the session.

Parent/Guardian Signature: ____ **Date:** ______________

Payment Terms: On or Prior to program Start Date

Reminder: Please include your child's name and the invoice reference with your payment.

Detach and enclose this coupon with your payment. Check or Money Order only

- -

REMITTANCE	
Student's Name:	WRITE YOUR CHILD'S NAME HERE
Invoice Reference:	Lunch
Payee Name:	The Parris Foundation, Inc.
Address:	414 West 145th Street
City, St Zip:	New York, NY 10031
Amount Enclosed:	$

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** ☐ 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

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

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: ________ weeks gestation

☐ Complicated by ______

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* ______

☐ Foods *(list)* ______

☐ 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)*: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Inhaled corticosteriod ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ 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)*
☐ **Other** *(specify)* ______

Explain all checked items above or on addendum

Medications *(attach MAF if in-school medication needed)* ☐ None ☐ Yes *(list below)*

Dietary Restrictions ☐ None ☐ Yes *(list below)*

PHYSICAL EXAMINATION

Height ______ **cm** (___ %ile)
Weight ______ **kg** (___ %ile)
BMI ______ **kg/m²** (___ %ile)
Head Circumference *(age ≤2 yrs)* ______ **cm** (___ %ile)
Blood Pressure *(age ≥3 yrs)* ______ / ______

General Appearance:

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

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)* ☐ Within normal limits

If delay suspected, specify below

☐ Cognitive *(e.g., play skills)* ______
☐ Communication/Language ______
☐ Social/Emotional ______
☐ Adaptive/Self-Help ______
☐ Motor ______

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
Hearing ☐ Pure tone audiometry ☐ OAE	__ / __ / __	☐ Normal ☐ Abnormal
Head Start Only		
Hemoglobin or Hematocrit *(age 9–12 mo)*	__ / __ / __	______ g/dL ______ %

Tuberculosis *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school*	*Date Done*	*Results*
PPD/Mantoux *placed*	__ / __ / __	Induration ______mm
PPD/Mantoux *read*	__ / __ / __	☐ Neg ☐ Pos
Interferon Test	__ / __ / __	☐ Neg ☐ Pos
Chest x-ray *(if PPD or Interferon positive)*	__ / __ / __	☐ Nl ☐ Abnl ☐ Not Indicated
Vision *(required for new school entrants and children age 4–7 yrs)*	__ / __ / __ ☐ with glasses	Acuity *Right* ___ / ___ *Left* ___ / ___ Strabismus ☐ No ☐ Yes

IMMUNIZATIONS – DATES CIR Number of Child ☐☐☐☐☐☐☐☐☐

Vaccine				
Hep B	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __
Rotavirus		__ / __ / __	__ / __ / __	__ / __ / __
DTP/DTaP/DT		__ / __ / __	__ / __ / __	__ / __ / __
		__ / __ / __	__ / __ / __	__ / __ / __
Hib	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __
PCV	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __
Polio	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __

Vaccine			
Influenza	__ / __ / __	__ / __ / __	__ / __ / __
MMR	__ / __ / __	__ / __ / __	__ / __ / __
Varicella	__ / __ / __	__ / __ / __	
Td	__ / __ / __	__ / __ / __	__ / __ / __
Tdap __ / __ / __	Hep A	__ / __ / __	__ / __ / __
Meningococcal	__ / __ / __	__ / __ / __	
HPV	__ / __ / __	__ / __ / __	__ / __ / __
Other, *Specify:* ______	__ / __ / __ ;	______	__ / __ / __

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet

☐ Restrictions *(specify)* ______

Follow-up Needed ☐ No ☐ Yes, for ______ Appt. date: __ / __ / __

Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision

☐ Other ______

ASSESSMENT ☐ **Well Child** (V20.2) ☐ **Diagnoses/Problems** *(list)* **ICD-9 Code**

______ __ __ __ __ __
______ __ __ __ __ __
______ __ __ __ __ __

Health Care Provider Signature | Date __ __ / __ __ / __ __

DOHMH ONLY **PROVIDER I.D.** ☐☐☐☐☐☐

Health Care Provider Name and Degree *(print)* | Provider License No. and State

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

Comments

Facility Name | National Provider Identifier (NPI)

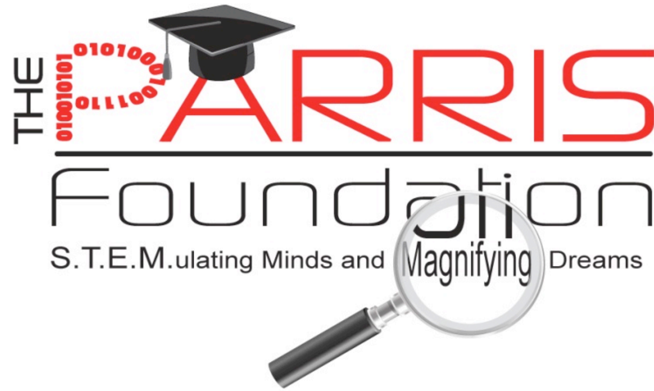
Address | City | State | Zip

Date Reviewed: __ / __ / __ | I.D. NUMBER ☐☐☐☐☐☐

Telephone (__ __ __) __ __ __ – __ __ __ __ | Fax (__ __ __) __ __ __ – __ __ __ __

REVIEWER:

Copies: **White** School/Child Care/Early Intervention/Camp, **Canary** Health Care Provider, **Pink** Parent/Guardian



RELEASE, WAIVER AND INDEMNITY

I hereby release, acquit, covenant to hold harmless and indemnify The Parris Foundation, Inc., and all other persons, firms, corporations and organizations associated with them, from all claims, damages, actions and causes of action of whatever nature may accrue to the said student or the undersigned, their heirs, executors, administrators, and legal representatives and assigns, arising out of any affiliation/student activity.

The undersigned further **grants permission** for said student **to be photographed and/or videotaped** with such pictures and names to be used in public relations and fundraising efforts to promote programs of The Parris Foundation, Inc. All photographs and video (negatives and/or positives) are solely and completely considered property of The Parris Foundation, Inc. If the undersigned student is under the age of eighteen years, his/her parent and/or legal guardian will also be required to execute this Release, Waiver and Indemnity. By doing so, the undersigned parent and/or legal guardian hereby releases The Parris Foundation Inc., the owners of the property upon which any volunteer activities are conducted, and their agents, employees, successors and assigns, from and hereby waive, all of the aforementioned liabilities, claims, demands, action, causes of action, expenses and damages in any way resulting from personal injury, conscious suffering, death or property damage sustained by the undersigned student and hereby agree to hold harmless, The Parris Foundation, Inc., the owners of the property upon which student activities are conducted, and their agents, employees, successor and assigns, from and against all losses, claims, demands, actions or proceedings of any kind which may be initiated against any of the foregoing by any person and arising out of any action or inaction on the part of The Parris Foundation, Inc. or such owner, agents, employees, successors, or assigns in any way related to any of Foundation activities or contemplated hereby.

____ ____

Student Name (Printed) Student Signature

____

Date

____ ____

Parent/Guardian Name (Printed) Parent/Guardian Signature (Printed)