THE MOUNT CARMEL
Early Childhood Center

Scholastic Year (2025-2026)

FORM #1: Emergency Information Form

Child's Name: _____ Gender: _____. D.O.B. _____

Allergies / Special Health Considerations: _____

Address: _____ Zip _____

Primary Email: _____

Parent #1: _____ Home: _____ Work: _____ Cell:_____

Parent #2: _____ Home: _____ Work: _____ Cell:_____

Persons, including parents, authorized to pick up child, their phone numbers and relationship to child. The Mount Carmel Early Childhood Center will dismiss your child at the end of each school day according to the information you provide below. If the information changes you must notify TMCECC immediately.

Name: _____ Cell: _____ Relationship: _____

Name: _____ Cell: _____ Relationship: _____

Name: _____ Cell: _____ Relationship: _____

Name: _____ Cell: _____ Relationship: _____

Child's Physician: _____ Phone: _____

Child's Dentist: _____ Phone: _____

Child's Health Insurance: _____ Policy: _____

Local Emergency Contact – if your child becomes ill and must be sent home from school and a parent cannot be reached:

Name: _____ Cell: _____ Relationship: _____

Name: _____ Cell: _____ Relationship: _____

Authorization: In the event that I or the above mentioned emergency contacts cannot be reached. I authorize The Mount Carmel Early Childhood Center to designate a doctor and/or hospital to initiate appropriate emergency medical services for my child/children.

Signature: _____ Date: _____ Relationship to child _____

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FORM #2: Sunscreen/Ointment Form

I herby permit the staff at The Mount Carmel Early Childhood Center to apply over the counter ointments, lotions, diaper rash creams, and/or sunscreen to my child, _____ as needed.

The over the counter product(s) I am providing is (check all that apply):

☐ sunscreen

☐ diaper rash cream/lotion/ointment

I have labeled the product(s) with my child's name. Application instructions, which are consistent with the instructions on the original container, are as follows:

_____

_____

_____

I also understand that the over the counter ointment/lotion/diaper rash cream and/or sunscreen that I am providing must not be stored in cubbies. These items will be kept inside designated, separate containers for each classroom.

Your Name: _____

Your Signature:

Date:

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FORM #3: APPROVED DROP-OFF/PICK-UP FORM

This form should be completed by families who have a consistent caregiver who will regularly be dropping off and/or picking up your child. Caregivers will receive an invitation to Remini via their email address and wil have their own code. **This person will be approved from September 2025 - June 2026.**

If a change occurs, and you need to remove an approved contact, please alert the office to this change.

Child's Name: _____

Caregiver's Full Name: _____

Caregiver's Email Address: _____

Caregiver's Phone Number: _____

Parent's Signature: _____

Date: _____

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** Last Name | First Name | ☐ **Foster Parent**

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:

	NI	Abnl		NI	Abnl		NI	Abnl		NI	Abnl		NI	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 _____ %

	Date Done	*Results*
Tuberculosis *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school*		
PPD/Mantoux *placed*	__/__/__	Induration _____mm
PPD/Mantoux *read*	__/__/__	☐ Neg ☐ Pos
Interferon Test	__/__/__	☐ Neg ☐ Pos
Chest x-ray *(if PPD or Interferon positive)*	__/__/__	☐ NI ☐ 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

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

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 __ __ / __ __ / __ __

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

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

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

DOHMH ONLY **PROVIDER I.D.**

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

Comments

Date Reviewed: __/__/__ **I.D. NUMBER**

REVIEWER:

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