therapy&learningcenter

Brooklyn's Early Childhood Program for All Learners
1723 Eight Avenue Brooklyn, NY 11215 • Phone (718) 290-2700 • Fax (718) 290-2800
www.tlckids.org

July 30, 2018

We are pleased and excited to welcome our new & continuing children to Therapy and Learning Center (TLC) for the 2018 – 2019 School Year. Thank you for choosing to enroll your child at TLC, we are happy to welcome you all!

This Packet contains:

- **Welcome Cover Letter / Important Dates**
- **Welcome Letter from *TLC's Education Director & School Supply List***
- **School Year Calendar**
- **TLC Staff Contact Information Sheet**
- **TLC 2018 – 2019 Enrollment Packet (Return to School)**
- **TLC Resources Packet**

Your child's medical is crucial for the first day of school. A medical form is good for one year from when the doctor dated the form, e.g. your child went 10/12/17 for a medical, that medical is valid until 10/12/18. All medicals are due by the first day of school for your child!

IMPORTANT DATES:

Tuesday, September 4TH , 2018	**2:00pm – 3:00pm Parent Orientation W/ Teachers** **3:00pm – 4:00pm Parent Orientation W/ Administrative Staff**
Wednesday, September 5, 2018 **8:30 am to 2:30 pm**	**First Day of School for all TLC Students!**
Wednesday, June 26, 2019	**Projected last day of the regular school year. *Pending inclement weather days or other school closings!***
Monday, July 8, 2019 **to Friday, August 16, 2019**	**Six week summer program (this is a separate tuition than the regular school year). Enrollment information will be available in February 2019 for the Summer 2019 Program.**

Thank you for choosing to enroll your child at TLC we are happy to welcome you all!

Sincerely,
The Administration, Faculty and Staff of Therapy & Learning Center, Inc.

Dear TLC Family,

At TLC we value the importance of social emotional development through play, teacher, therapist and student interactions and peer to peer interactions.

Please find for your information a copy of the TLC Behavior Management Policy and a copy of the learning program (Second Step Early Learning Program) used for Positive Behavior Intervention Support.

If you have any questions please feel free to contact the School Psychologist, Social Worker, Clinical Coordinator or Ed. Director.

School Supply List

It is important that you label everything you send for your child to TLC with their first name and last initial, i.e. "*School S.*".

- Backpack
- Communication Notebook – Composition notebooks work well!
- 2 Ziploc XL Big Bags. Boxes usually come with a supply of 4.
  (You may purchase at Amazon, Target, Dollar Tree, Walmart)
- Blankets (Mat are 25" X 52")
- Fitted Twin size Sheet
- Pillow – a small one for rest mat.
- Diapers/Pull-ups – You can send a supply for the week or month.
- Diaper Wipes
- Complete change of clothes including underwear and socks

Certain classrooms may ask for other things, please review your Classroom Teacher's letter!

Thank You! ☺

2018/19 T LC School Calendar

September 2018						
Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

October 2018						
Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

November 2018						
Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

December 2018						
Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

January 2019						
Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

February 2019						
Su	Mo	Tu	We	Th	Fr	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28		

March 2019						
Su	Mo	Tu	We	Th	Fr	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

April 2019						
Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

May 2019						
Su	Mo	Tu	We	Th	Fr	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

June 2019						
Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

July 2019						
Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

August 2019						
Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Holiday and School Closings 2018/19

Sept. 4: Staff Orientation (No Students)
Sept.5: First Day of School
Sept. 10,11: Rosh Hashanah(Closed)
Sept. 19: Yom Kippur (Closed)
Oct. 8: Columbus Day (Closed)
Nov. 6: Staff Development (No Students)
Nov. 12: Veterans Day (Closed)
Nov, 22,23: Thanksgiving Break (Closed)
Dec. 24-Jan. 1: Winter Recess (Closed)
Jan. 21: MLK Day- (Closed)
Feb. 5: Lunar New Year- (Closed)
Feb. 12: Staff Development (No Students)
Feb.18-22: Mid-Winter Recess (Closed)
Mar.15: Staff Development Day (No Students)
April. 19-26: Spring Recess (Closed)
May 27: Memorial Day (Closed)
Jun 4: Eid al-Fitr (Closed)
Jun 6: Staff Development (No Students)
Jun. 26: Last Day of School

TLC STAFF CONTACT INFORMATION

Staff Name	Contact Information	Telephone Number	Email
Timothy Behr	Executive Director	718-290-2750	**Timothy.behr@tlckids.org**
Margot Sigmone	Ed. Director	718-290-2717	**Margot.sigmone@tlckids.org**
Kathy Christian	Clinical & IEP Coordinator	718-290-2719	**Kathy.christian@tlckids.org**
Philomena Schiano	Program Manager	718-290-2740	Philomena.schiano@tlckids.org
Jordana Kenny	Social Worker	718-290-2727	Jordana.kenny@tlckids.org
Angie Sjoquist	Psychologist	718-290-2722	Angie.sjoquist@tlckids.org
Arielle Gannon	Nurse	718-290-2715	Nurse@tlckids.org
Shatorie Williams	Ed. Director Administrative Assistant/Enrollment Coordinator	718-290-2718	Shatorie.williams@tlckids.org
Venus Rodriguez	Administrative Assistant	718-290-2725	Venus.rodriguez@tlckids.org
Miriam King	Transportation Coordinator	718-290-2744	Miriam.king@tlckids.org

School Messenger- Updates SENT as needed. Please ensure your telephone number, contact and email information are correct.

Parent Reply Sheet Therapy & Learning Center | 2018-2019

Early Drop Off and Late Pick UP
Beginning Wednesday, September 12, 2018

TLC has an Early Drop Off (EDO 8:00-8:30 am) & Late Pick-Up (LPU 2:30-4:00 pm) program. All families are welcome to use this program however, please note:

- There is a fee of $24.00 per hour for the program.
- This is a free flowing program with less structure than the classroom day.
- Three seasoned Teacher Assistants guide the EDO & LPU program.
- This is not a program that would benefit a child who needs a highly structured program and direct one to one attention.
- Depending upon weather the rooftop playground, indoor gross motor room, or a classroom will be utilized for EDO or LPU.
- A sign will be posted by the front desk or you can ask the receptionist where EDO or LPU is taking place.
- **No longer will requests be honored for LPU on the same day**. This is to ensure that there are safe numbers in the group.
- Due to the increase in specific food allergies/sensitivities no longer will school snack be provided. If you wish for your child to have a snack please send items in their lunch box/bag that is clearly labeled for EDO or LPU. Children will be able to have water as needed.

CPSE parents who wish for their children to participate in this program, must bring and pick up their child. ***There is no bussing service*** available with this program.

For planning purposes, please complete and return this form ASAP.

_____ Yes, I am interested in using TLC Early Drop Off (8:00 AM – 8:30 AM) everyday, Monday through Friday.

_____ Yes, I am interested in using TLC Early Drop Off on the following days:

Circle: Monday, Tuesday, Wednesday, Thursday, Friday

_____ Yes, I am interested in using Late Pick-Up (2:30– 4:00 PM) everyday, Monday through Friday.

_____ Yes, I am interested in using Late Pick-Up on the following days:
Circle: Monday, Tuesday, Wednesday, Thursday, Friday

Space is limited; please send in your reply ASAP!

TLC

Therapy and Learning Center, Inc.

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Phone: (718) 290-2700 Fax: (718) 290-2800
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2018-2019 ENROLLMENT PACKET

!!!!!!!!!!!!!!!!!!!!!!!!!!ATTENTION PARENTS!!!!!!!!!!!!!!!!!!!!

Please return all documents in the enrollment packet before your child (ren) begins.

Documents check list:

- ✓ Updated Medical with Immunizations
- ✓ Cumulative Health Record Form
- ✓ Over the Counter Medication (OTC) Form

- ❖ **(IF YOUR CHILD HAS AN IEP**, YOU MUST RETURN THESE 2 FORMS ***(Listed inside this text box)*** TO ENSURE RELATED SERVICES ARE PROVIDED & BUSSING TO TAKE EFFECT IMMEDIATELY.)
- ❖ Medical Prescription Form **(Sign & Stamped By Physician)**
- ❖ Transportation Form

- ✓ HIPPA Form
- ✓ NYU Dental Van Screening Form
- ✓ School Messenger Form
- ✓ CACFP Form
- ✓ COPY OF BIRTH CERTIFICATE
- ✓ COPY OF GOVERNMENT ISSUE ID OF THE PARENT / & RECENT PHOTO OF CHILD(REN)
- ✓ TLC Forms:
  - **TLC Emergency Home Contact Form**
  - **TLC Emergency Medical Permission Form**
  - **TLC Photograph & Video Consent Form**
  - **TLC School Trip Consent Form**
  - **TLC Confidentiality & Parental Access to Records Form (1 Copy)**

ALL Documents MUST be completed & returned by: 8/27/2018

Please only inform school administration, if you plan to relocate to a new borough or change your address within your borough.

Please IMMEDIATELY notify school administration if you are NOT accepting placement at Therapy and Learning Center

**Parents, please note that changing a students' class placement when deemed beneficial to the child can occur within the school year. Changes are discussed as a team (parents included). You will receive prior notification if such situation may arise.*

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Family Documents Checklist

Child Name:_____ **Parent Name:**_____

Please place a check (✓) next to all documents included in the Return Packet. In addition, your Checklist should be the first page of your returned documents.

- ○ Birth Certificate
- ○ Updated Medical with Immunizations (Up to Date)
- ○ Cumulative Health Record Form

❖ **(IF YOUR CHILD HAS AN IEP,** *(The 2 forms listed inside this text box must be included in your return packet.)*

- ○ Medical Prescription Form **(Include NPI #, Sign & Stamped By Physician)**
- ○ Transportation Form

- ○ Over the Counter Medication (OTC) Form
- ○ HIPPA Form
- ○ NYU Dental Van Screening Form
- ○ School Messenger Form
- ○ CACFP Form
- ○ TLC Forms
  - ○ TLC Emergency Home Contact Form
  - ○ TLC Emergency Medical Permission Form
  - ○ TLC Photograph & Video Consent Form
  - ○ TLC School Trip Consent Form
  - ○ TLC Confidentiality & Parental Access to Records Form (RETURN 1 Copy)
  - ○ Government Issued Photo ID of the Parent/Guardian
  - ○ Recent Photo of student

REMINDER!!!

START DATE WILL BE DELAYED IF UPDATED ***MEDICAL, IMMUNIZATIONS & CUMULATIVE FORMS*** ARE NOT RECEIVED BY DUE 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: O Female O Male | Date of Birth (Month/Day/Year)

Child's Address | Hispanic/Latino? O Yes O No | Race (Check ALL that apply) O American Indian O Asian O Black O White O Native Hawaiian/Pacific Islander O Other

City/Borough | State N.Y. | Zip Code | School/Center/Camp Name | District Number | Phone Numbers: Home, Cell, Work

Health Insurance (including Medicaid)? O Yes O No | O Parent/Guardian O Foster Parent | Last Name | First Name

TO BE COMPLETED BY HEALTH CARE PROVIDER — Typed or Printed Clearly (Additional addendum if needed)

Birth history *(age 0-6 yrs)*

O Uncomplicated O Premature: _____ weeks gestation

O Complicated by _____

Allergies O None O Epi pen prescribed

O Drugs *(list)* _____

O Foods *(list)* _____

O Other *(list)* _____

Does the child/adolescent have a past or present medical history of the following?

O Asthma *(check severity and attach MAF/Asthma Action Plan):* O Intermittent O Mild Persistent O Moderate Persistent O Severe Persistent

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

O Attention Deficit Hyperactivity Disorder
O Chronic or recurrent otitis media
O Congenital or acquired heart disorder
O Developmental/learning problem
O Diabetes *(attach MAF)*
O Orthopedic injury/disability
O Seizure disorder
O Speech, hearing, or visual impairment
O Tuberculosis *(latent infection or disease)*
O Other *(specify)* _____

Explain all checked items above or on addendum

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

Dietary Restrictions
O None O 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
HEENT	O	O
Dental	O	O
Neck	O	O
Lymph nodes	O	O
Lungs	O	O
Cardiovascular	O	O
Abdomen	O	O
Genitourinary	O	O
Extremities	O	O
Skin	O	O
Neurological	O	O
Back/spine	O	O
Psychosocial Development	O	O
Language	O	O
Behavioral	O	O

Describe abnormalities:

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

If delay suspected, specify below

O Cognitive *(e.g., play skills)* _____
O Communication/Language _____
O Social/Emotional _____
O Adaptive/Self-Help _____
O 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)*	___/___/___	O At risk *(do BLL)* O Not at risk
Hearing O Pure tone audiometry O OAE	___/___/___	O Normal O 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*	___/___/___	O Neg O Pos
Interferon Test	___/___/___	O Neg O Pos
Chest x-ray *(if PPD or Interferon positive)*	___/___/___	O Nl O Not O Abnl Indicated
Vision *(required for new school entrants and children age 4-7 yrs)*	___/___/___ O with glasses	Acuity *Right* ___/___ *Left* ___/___ Strabismus O No O Yes

IMMUNIZATIONS — DATES

CIR Number of Child

Hep B	___/___/___	___/___/___	___/___/___	___/___/___
Rotavirus	___/___/___	___/___/___	___/___/___	___/___/___
DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___
	___/___/___	___/___/___	___/___/___	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___
MMR	___/___/___	___/___/___	___/___/___	___/___/___
Varicella	___/___/___	___/___/___	___/___/___	
Td	___/___/___	___/___/___	___/___/___	___/___/___
3dap	___/___/___	Hep A	___/___/___	___/___/___
Meningococcal	___/___/___	___/___/___	___/___/___	
HPV	___/___/___	___/___/___	___/___/___	___/___/___
Other, *specify:*	___/___/___			___/___/___

RECOMMENDATIONS

O Full physical activity O Full diet
O Restrictions *(specify)*
Follow-up Needed O No O Yes, for _____ Appt. date: ___/___/___
Referral(s): O None O Early Intervention O Special Education O Dental O Vision
O Other _____

ASSESSMENT

O Well Child (V20.2) O 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

CH-205 (5/08)

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

CENTER NAME: Therapy and Learning Center, INC.

ADDRESS: 1723 Eighth Avenue

BORO: Brooklyn, New York 11215

318K (REV. 8/02)

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BUREAU OF DAY CARE

DAY CARE CUMULATIVE HEALTH RECORD

TO BE COMPLETED BY PARENTS/GUARDIANS AND DAY CARE STAFF

Date of Admission ___/___/___

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

TLC

Therapy and Learning Center, Inc.

1723 8th Avenue, Brooklyn, N.Y. 11215
Phone: (718) 290-2700 Fax: (718) 290-2800
www.tlckids.org

Dear Parents,

Attached please find a DOH/DOE ***Order for School Health Related Support Services*** Form for Speech, OT, PT, and/or Feeding Services. If your child's current evaluations and IEP, indicate that he/she needs therapy services, please bring the form to your child's doctor as soon as possible.

***THE ENCLOSED FORM NEEDS TO BE FILLED OUT, STAMPED, NPI# INCLUDED, AND SIGNED BY THE DOCTOR IN ORDER FOR YOUR CHILD TO RECEIVE THERAPY.**

It is now required that the attached form be completed by the doctor before your child can start receiving the indicated services. Your child will not be able to receive services until we receive the appropriate prescription.

Thank you for your cooperation and assistance.

If you should have any questions please feel free to contact the Nurse at (718) 290-2715.

Sincerely,
Registered Nurse
TEL. (718) 290-2715

Doctor, Nurse Practitioner or Physician Assistant
Order for School Health Related Support Services

Student Name: _____ _____
First Last

Birth Date: _____ / _____ / _____ NYC Student ID: _____
Month Day Year OSIS #

I have reviewed the recommendations on the student's IEP with respect to the therapies below and in my opinion, the following services are deemed medically necessary:

for each therapy on the student's IEP, mark one column and include ICD Code(s)

please blacken a circle only for services on the IEP

	Service IS Medically Necessary	Service, as written, IS NOT Medically Necessary	ICD Code(s) associated with each service
Occupational Therapy	○	○	
Physical Therapy	○	○	
Speech Therapy	○	○	

_____ _____
Ordering Doctor, PA or NP's Signature (an original signature is required) Date

_____ _____
Ordering Doctor, PA or NP's Name Ordering Doctor, PA or NP's License Number

_____ _____
Address (Street) Ordering Doctor, PA or NP's NPI Number

_____ _____
Address (City, State, ZIP) Ordering Doctor, PA or NP's Medicaid Provider ID Number

_____
Telephone Number

REMINDER!!!

IF YOUR CHILD IS REQUIRED TO RECEIVE PRESCRIPTION MEDICATIONS, PLEASE HAVE THE:

- **DOCTOR COMPLETE FORMS "B" AND "C"**
- **PARENT PLEASE COMPLETE FORM "A"**

THANK YOU.

A

Therapy & Learning Center
EMERGENCY MEDICAL PERMISSION FORM

1723 8th Avenue, Brooklyn, NY 11215 Tel: (718) 290-2700 Fax: (718)290-2800

DATE: ___/___/___

Student's Name: _____ DOB: ___/___/___

Special Alerts/Allergies:

Medications:

Parent/Guardian's Name: _____

Work Telephone #: ___-___-____

Home Telephone #: ___-___-____

In case of an emergency please contact:	Telephone # :	Relationship
1.		
2.		
3.		

Please fill out if applicable:	
Foster care agency:	
Contact person :	
Telephone # :	
Supervisor at agency:	

I have received and reviewed TLC's policy on child sickness and accidents. I understand that I will be required to pick-up my child if an illness/accident requires me to do so.

I hereby give TLC permission to have emergency medical treatment administered, if necessary by the school nurse.

I hereby also grant the TLC permission to obtain necessary emergency medical treatment, including an ambulance, and emergency room treatment, if necessary.

I understand that I, or if I cannot be reached, a person listed above, will be contacted in case of a serious illness and/or emergency.

_____ _____

Parent/Guardian Signature Date

OCFS-LDSS-7002 (11/2004)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

WRITTEN MEDICATION CONSENT FORM

- This form must be completed in a language in which the child care provider is literate.
- One form must be completed for each medication. Multiple medications cannot be listed on one consent form.

LICENSED AUTHORIZED PRESCRIBER MUST COMPLETE THIS SECTION (#1 - #18)

(Parents may complete #1- #17 (omit #18) for over-the-counter topical ointments, sunscreen and topically applied insect repellent)

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:
4. Name of medication (including strength):	5. Amount/dosage to be given:	6. Route of administration:

7A. Frequency to be administered: _____

OR

7B. Identify the symptoms that will necessitate administration of medication: (signs and symptoms must be observable and, when possible, measurable parameters) _____

8A. Possible side effects: ☐ See package insert for complete list of possible side effects (parent must supply)

AND/OR

8B: Additional side effects: _____

9. What action should the child care provider take if side effects are noted:

☐ Contact parent ☐ Contact prescriber at phone number provided below

☐ Other (describe): _____

10A. Special instructions: ☐ See package insert for complete list of special instructions (parent must supply)

AND/OR

10B. Additional special instructions: (Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situations when medication should not be administered.) _____

11. Reason the child is taking the medication (unless confidential by law): _____

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and require health and related services of a type or amount beyond that required by children generally?

☐ No ☐ Yes If you checked yes, complete #33-#34 on the back of this form.

13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered?

☐ No ☐ Yes If you checked yes, complete #35-#36 on the back of this form.

14. Date prescriber authorized:	15. Date to be discontinued or length of time in days to be given *(this date cannot exceed 6 months from the date authorized or this order will not be valid)*:
16. Prescriber's name (please print):	17. Prescriber's telephone number:

18. Licensed authorized prescriber's signature:

X

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

WRITTEN MEDICATION CONSENT FORM

PARENT/GUARDIAN MUST COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? (For example, did the prescriber write 12pm?) ☐ Yes ☐ N/A ☐ No

Write the specific time(s) the day care program is to administer the medication (i.e.: 12pm): _____

20. I, parent/legal guardian, authorize the day care program to administer the medication as specified in the "Licensed Authorized Prescriber Section" to _____
(child's name)

21. Parent or legal guardian's name (please print):	22. Date authorized:

23. Parent or legal guardian's signature:
X

DAY CARE PROGRAM TO COMPLETE THIS SECTION (#24 - #30)

24. Provider/Facility name:	25. Facility ID number:	26. Facility telephone number:

27. I have verified that #1-#23 and if applicable, #33-#36 are complete. My signature indicates that all information needed to give this medication has been given to the day care program.

28. Authorized child care provider's name (please print):	29. Date received from parent:

30. Authorized child care provider's signature:
X

ONLY COMPLETE THIS SECTION (#31-#32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

31. I, parent/legal guardian, request that the medication indicated on this consent form be discontinued on _____
(date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent or Legal Guardian's Signature:
X

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #36)

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.

34. Licensed Authorized Prescriber's Signature:
X

35. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date by which you expect the pharmacy to fill the updated order.

DATE:

By completing this section the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

36. Licensed Authorized Prescriber's Signature:
X

Therapy and Learning Center Inc.

School Year : 2018 - 2019

New Forms must be completed every year

PARENT PERMISSION TO GIVE "OCCASSIONAL" OVER- THE -COUNTER MEDICATION

Student Name_____ D.O.B:_____ Class:_____

Teacher:_____

Over-the-counter (OTC) medications are drugs that do not require a prescription and are purchased "over-the-counter." This form is required before over-the-counter medications can be administered at school. Exceptions to this are homeopathic/herbal medications and aspirin, which require completing the form "Permission to Give Prescription/Homeopathic Medication at School."

PLEASE INITIAL EACH MEDICATION FOR WHICH YOU ARE GIVING PERMISSION

_____ I approve all medications listed below

_____ I do not want any OTC meds given to my student

TOPICAL:

☐ Antibiotic Cream (i.e Bacitracin Cream)
☐Hydrocortisone cream (Cortaid)
☐Benadryl Cream
☐Sunscreen spray
☐Sunscreen lotion

Please check with the school nurse to see which medications are available for students in the school clinic and which medications you will need to supply. OTC medications will be given at the manufacturer's recommended dosage.

THE MEDICATION ABOVE MAY BE ADMINISTERED TO MY CHILD

_____ _____

(Signature of Parent or Guardian) **(Date)**

When sending OTC medications to school, they must be in the original manufacturer's container with the label intact or the medication will not be accepted. For safety reasons, parents are requested to bring the medication directly to the nurse. The medication should be sealed in an envelope in the original manufacturer's container. In the event that an adult is unable to bring the medicine to school, arrangements may be made by calling the nurse.

The school is not able to supply medication for frequent or daily use. For OTC medications not listed on this form, or if the medication must be given daily, please contact the School Nurse.

MEDICATION HISTORY:

Is your child allergic to any medications? _____

If yes, please list medicine(s) and type of reaction: _____

_____

Does your child take any medication (either over-the-counter or prescription) on a regular basis?

☐Yes ☐No

If yes, please list:_____

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Therapy and Learning Center, Inc. | 2018-2019

Transportation Form

Reminders:

- TLC's bussing company is ***L & M Bus Company (718-257-2082).***
- OPT requires that all programming for CPSE children who require bussing takes place through a child's school program.

TLC must apprise OPT of any changes to **address, pick up, or drop off changes, and/or who is eligible for bussing services.**

- **TLC requires 10 business days or more to make any new changes** with OPT.
- **No longer will BUS COMPANIES be able to accommodate same day changes for pick up or drop off for your child.** You will be required to pick up your child from school or the address that is on file at OPT.

❖ **Miriam King, is TLC's CPSE Transportation Coordinator, 718-290-2744.**

❖ **Email: Miriam.king@tlckids.org**

Below, fill in your *Child's Name & Class.* Place a check (√) next to the option of your choice, *sign & date the form* and provide your child's *Pick-Up & Drop-Off*, information for Bussing Service.

Child's Name: _____ Class: ____

☐ **Yes**, I will utilize the bussing service provided by NYC DOE's Office of Pupil Transportation (OPT).

☐ **No**, I will **NOT** utilize the bussing service provided by NYC DOE's Office of Pupil Transportation (OPT).

Parent Signature: _____ **Date**: _____

Pick-Up & Drop-Off Information

Pick-Up Address: _____ Tel.#: _____

_____

Drop-Off Address: _____ Tel.#: _____

_____

***Name of Person taking child off bus**: _____

***TEL. #**: _____

SchoolMessenger

TLC contracts with "*SchoolMessenger*" a leading provider of on demand notification solutions for the education market. TLC uses *SchoolMessenger* to notify families of school closures due to inclement weather closings or school emergencies. Please provide primary and secondary telephone numbers and emails for those family members who should be contacted if school will be closed or there is an emergency while school is in session. *SchoolMessgener* generates automated telephone messages and emails.

Child's Name: _____ Class# _____

Primary Parent/Guardian:

Name: _____

Telephone#: _____

Email Address: _____

Secondary Parent/Guardian:

Name: _____

Telephone #: _____

Email Address: _____

Please indicate language preference for notification:

- ○ Arabic
- ○ English
- ○ Spanish

DEAR PARENTS,

<u>*PLEASE ENCLOSE A COPY OF PARENT(S):</u>

STATE I.D. / DRIVER'S LICENSE or GOVERNMENT I.D. with PARENT(S) PHOTO.

<u>PLEASE ENCLOSE A RECENT PHOTO OF YOUR CHILD.</u>

PLEASE BE ADVISED *<u>ANYONE LISTED ON THE PICK UP LIST MUST PRESENT I.D.</u>* TO THE SCHOOL BEFORE A CHILD IS RELEASED.

THANK YOU.

TLC EMERGENCY HOME CONTACT

Student's Name_____ **Date of Birth**_____ **Class**_____

Sex_____Male_____Female

Name of Mother/Guardian_____

Home Address_____

Home Phone #_____ Cell #_____ E-mail_____

Work Phone #_____ Cell #_____

Name of Father/Guardian_____

Home Address_____

Home Phone #_____ Cell #_____ E-mail_____

Work Phone #_____ Cell #_____

Parent Home Language

Written_____

Oral_____

NOTE: Please list below any and all persons to call if your child is sick or needs to be picked up for any other reason. If none of the contacts can be reached by phone, what do you wish the school to do in case the child is sick in school?

_____

MEDICAL ALERT: My child has the following medical condition:_____
And I will obtain the correct authorization forms from the school office for treatment.

CUSTODIAL ALERT: I request that my child may not be released to_____ and I will provide the proper legal documentation to the school office to substantiate this request.

It is understood that in the final disposition of any emergency case, the judgment of the school authorities will prevail. The recommendation of the parent or guardian will be respected as far as possible. If at any time the above information must be changed, I will notify the Executive Director in writing.

Parent/Guardian's Signature:_____ Date_____

OTHER CONTACTS

NAME & RELATION	PHONE NUMBER	EMAIL CONTACT
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Therapy & Learning Center

PHOTOGRAPH & VIDEO CONSENT FORM

Tel: (718) 290-2700 Fax: (718) 290-2800

DATE: ___/___/___

Student's Name: _____ D.O.B. _____

I, _____, hereby grant permission to TLC for photographs and videos of my child _____ to be taken in school and displayed in the school/classroom for educational purposes. I understand that photographs and videos will not be used outside of the school or for any other purpose without my consent.

_____ _____

Parent/Guardian signature Date

Therapy & Learning Center

SCHOOL TRIP CONSENT FORM

Tel: (718) 290-2700 Fax: (718) 290-2800

Date: ___/___/___

Student's Name: _____ DOB: ___/___/____

I, _____, ☐ do / ☐ do not give permission to TLC for my child _____ to go on various short walks and trips in the neighborhood, including: class walks, visits to the park, playgrounds, stores, and other points of interest, as part of my child's educational and clinical program, with his/her teacher/therapist. I also understand that a separate permission slip will be sent home for all trips that require a bus or other transportation. I will then give or not give my permission for my child to attend that trip. The need for my attendance on such a trip will be determined on a specific basis.

_____ _____

Parent/Guardian signature Date

TLC

Therapy and Learning Center, Inc.

1723 8th Avenue, Brooklyn, N.Y. 11215
Phone: (718) 290-2700 Fax: (718) 290-2800
www.tlckids.org

Dear TLC Families,

Enclosed, please find 2 copies of TLC's Confidentiality and Parental Access to Records policy, one inside of your Return Packet *(For our records)* and one inside of you Resources Packet *(For your records)*. We are required by law to inform you of your rights to see your child's file at TLC and what the procedure is to view a file. For students returning to TLC, we are required to provide you with this policy and update our records annually.

Please read the policy and put the date, your child's name, your name, and your signature at the bottom of one (1) of the forms. Please keep the second copy for your records. Please return it along with all other documents. Thank You.

Sincerely,

Therapy and Learning Center, Inc.

TLC

Therapy and Learning Center, Inc.

1723 8th Avenue, Brooklyn, N.Y. 11215
Phone: (718) 290-2700 Fax: (718) 290-2800
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"PLEASE RETURN COMPLETED FORM"

CONFIDENTIALITY & PARENTAL ACCESS TO RECORDS

TLC keeps an individual file for each child containing evaluations, service plans (IEP), related service(s) records, progress reports, notices, attendance and health records.

This file is kept in a records room in the school, which is locked at all times. Each child's file is confidential and may only be viewed by authorized TLC Personnel who collect or use information for the express purposes of facilitating the child/family's participation in the child's program. These providers may include teachers, social worker, nurses, psychologists, speech, occupational and physical therapists as well as designated administrative personnel.

Parents/Legal guardians have a legal right to review and inspect their child's educational records at any time, unless the parent is otherwise prohibited such access under State or Federal Law. For children in the care and custody or custody and guardianship of the local social services district, the local Commissioner of Social Service or Designee shall be accorded access to the child's records. Where any part of the record contains information on more than one child, the parent shall only have the opportunity to review and inspect the portion of the record, which pertains to their child.

Parents/Legal guardians can inspect and review their child's educational file at any time at the school and may obtain a copy of the record within ten working days of the receipt of their request, and/or within five working days if their request is made as part of mediation or impartial hearing. Copies of their child's records will be provided at no charge for the first copy and at 25 cents per page for any additional copies of the record. Understandable explanations about and/or interpretations of the record upon the parent's request will be provided.

Parents/Legal guardians are requested to adhere to the following procedure, when accessing their child's records:

1. ***Parents/Legal guardians must contact their Education Director at TLC to set up an appointment to review records.***
2. ***The Education Director or his/her designee, signs out the student file and logs in the date, name of student, and reason for file review in the sign-out book, located in the locked records room.***
3. ***The Education Director or his/her designee, brings the student file to a private room for the parent and/or legal guardian to review, and remains in the room to answer any questions.***
4. ***The Education Director or his/her designee provides the parent and/or legal guardian with copies if requested.***
5. ***The Education Director or his/her designee returns the student file to the records room.***

Date: ____/____/____

Student's Name: _____

Parent/Guardian's Print Name: _____

Parent/Guardian Signature: _____

TLC

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4. ***The Education Director or his/her designee provides the parent and/or legal guardian with copies if requested.***
5. ***The Education Director or his/her designee returns the student file to the records room.***

Date: ____/____/____

Student's Name: _____

Parent/Guardian's Print Name: _____

Parent/Guardian Signature: _____

Child and Adult Care Food Program

Dear TLC Families,

Please note that your indication of your income of the form is only utilized by the program to verify the "Dollar Rate" at which the program will be reimbursed for the meals for your child.

The program is reimbursed based on the following rate categories:

Free, Reduced or Paid. Please fill in all information on the sheet as it is only used by the school.

Department of Education

REQUEST FOR CONSENT
FOR MEDICAID REIMBURSEMENT

Dear Parent or Guardian,

I'm writing to ask for your assistance as we work to provide services for your child. Our schools can receive additional funding for some of the services that are provided to students, like your child, who have individualized education plans (IEPs). In order for our schools to receive this funding, we need your consent to (1) access and provide to the state and federal Medicaid programs personally identifiable information from your child's special education records about the special education evaluations, programs and services that are provided to your child and (2) access your child's Medicaid benefits to pay for these services. Please read the information below, complete the attached form and return it to your child's school.

Thank you for your assistance in ensuring that our public schools receive as much funding as possible for the critical supports that are provided to our students.

Sincerely,

Carmen Fariña
Chancellor

Why am I being asked to sign this consent form?

The New York City Department of Education (NYC DOE) uses Medicaid funding to help meet some of the costs of providing special education services to students. With your consent, the NYC DOE can submit claims for evaluations and services that are provided to your child. You are not required to sign up for Medicaid in order for your child to receive the services on his/her IEP.

What information about my child will be provided to state and federal Medicaid programs?

The NYC DOE will provide personally identifiable information about the special education evaluations and services provided to your child. This information may include the IEP, progress notes, attendance records, evaluations and other records and information about evaluations and services provided to your child.

Is there any cost to me or to my family?

There is no cost to you or your family. You will not be required to incur any expenses, premiums, costs or copayments for the provision of these services. The services that are provided to your child in and outside of school will not be affected in any way. If your family receives Medicaid benefits, your coverage will not be canceled, the lifetime coverage in place will not decrease and services that your family receives will not be affected in any way by the accessing of Medicaid benefits. You will not be required to sign up for or enroll in Medicaid for your child to receive the services on his/her IEP. You will not risk the loss of eligibility for home and community based waivers, if any, that are based on your total health-related expenditures.

Can I change my mind about allowing the NYC DOE to access my child's information and submit claims to the Medicaid program? What if I do not provide my consent?

You may change your mind about this consent at any time. To change your decision, complete a new form and send it to your child's school. The NYC DOE must still provide special education and services to your child at no cost to you even if you do not consent or you withdraw your consent at a later date.

Department of Education

CONSENT TO RELEASE INFORMATION FOR MEDICAID REIMBURSEMENT

Student's last name	*Student's first name*	*Date of birth*	*NYC Student ID*

Please select one choice below, sign and date the document, and return this form to your child's school.

○ Yes, I understand and agree that the NYC DOE may access my child's special education records, which may include the Individualized Education Program (IEP), progress notes, attendance records, evaluations and other records and information about services and evaluations that may be provided to my child and release this personally identifiable information to State and Federal Medicaid agencies as necessary to claim Medicaid reimbursement. I agree that the NYC DOE may access my child's Medicaid benefits to pay for special education and services provided as per my child's IEP.

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

○ No, I do not give permission for the NYC DOE to access my child's special education records to claim Medicaid reimbursement for special education services provided to my child.

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____