Machaneh Ohr Shraga
1102 Avenue L
Brooklyn, NY 11230

Tel. 718.252.7777
Fax. 718.252.7797
Email. mos@ohrshraga.org

Rabbi Yitzy Riselheimer, Head Counselor
Rabbi Ezra Netanel, Division Head

Rabbi Yossi Simon, Learning Director
Mrs. Rachel Krieser, Preschool Director

January 2018

Dear Parents,

With great anticipation we announce the kickoff of our registration for **Machaneh Ohr Shraga Summer 2018 Season**, our **15th year**.

Since its inception, Machane Ohr Shraga's vision is to provide a truly unique summer experience. By keeping enrollment limited and hiring the most qualified staff, we strive to provide our campers with the best possible summer experience.

Our superb learning program is under the outstanding supervision of Rabbi Yosef Simon. Our exciting afternoon program is divided into **4 divisions**.

Senior Division - Grades 5-8: This program includes daily swimming, extended hours until 6:00 PM daily, weekly night programs, separate exciting trips including overnight trips, and much more.

Intermediate Division - Grades 2-4: This program includes daily swimming, 2 major trips, exciting weekly trips, individual leagues and much more.

Junior Division - Grades Pre1A-1: This program includes daily swimming, exciting weekly trips, fun and much more.

Preschool Division:
Ohr Shragalech – Grades PreNursery – Kdg (PreNursery- boys & girls must be toilet trained): This program includes daily swimming (on premises), creative program, arts-n-crafts, baking, and trips.

Please refer to our supplementary fact sheet for a better understanding of our registration process, prices, deadlines, etc.

Once again, we look forward to spending an enjoyable fun-filled summer together.

Sincerely,
Yaakov Yosef Kalisch
Director

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Machane Ohr Shraga Fact Sheet

Registration:

- Please fill out your registration contract and return it to our office along with the financial requirements (as depicted in the "Price" section), and the other necessary forms. **Registration is only considered complete if it is returned along with the financial requirements (deposit & head check or authorized CC) and lunch form.** Experience has taught us that many parents delay their application submission because they do not have the health forms from the doctor. We recommend that you send back all other forms first so that we can get your son in the roster and then follow up with the health forms ASAP.

- **Schedule:**
  - **1st Trip – Wednesday, June 27th – Monday, July 23rd**
  - **2nd Trip – Tuesday, July 24th – Thursday, August 16th**

Hours & Fees

These fees include the cost of registration, nutritious breakfast, lunch and snacks, insurance, regular weekly trips*, in-house shows and programs.

▪ Ohr Shraga'lech 9:00 AM – 3:30 PM
PreNursery (must be toilet trained), Nursery, & Kindergarten
Price: full: $1000 half: $550 **Extended hour optional**- call for details**.**
Transportation fee: $50 per child
Trip & Entertainment Fee: full: $85 half: $60

▪ Grades Pre1A-1 9:00 AM – 4:30 PM
Price: full: $1200 half: $650
Transportation fee: $50 per child
*Note: Major Trips are not included in the day camp fee

▪ Grades 2-4 9:00 AM – 4:30 PM
Price: full: $1375 half: $700
Transportation fee: $50 per child
*Note: Major Trips are not included in the day camp fee

▪ Grades 5–8 9:00 AM – 6:00 PM. (Late night once a week – supper included)
Price: full $1500 half: $775
Transportation fee: $100 per child ($50 per route)
*Note: Overnight trips are not included in the day camp fee.

▪ Friday schedule
All grades 9:00 AM – 1:00 PM. Breakfast and lunch served

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Transportation:

Air Conditioned Buses.

Please note that transportation must be requested in the application. Our transportation arrangements are made based on application requests. Every effort will be made to accommodate every camper to the best of our ability. **We cannot guarantee transportation to every location in Brooklyn.**

Payments:

A 50% deposit per camper is required upon registration. In addition, we must receive a second head check or cc for the balance dated for no later than June 25th. To pay by credit card, please include your information on the registration contract, and make sure to indicate and authorize the dates and amounts that you would like your card to be charged.

All balances MUST be paid in full by Monday, June 25th! *We cannot guarantee to hold your slot if full payment is not received by then, and we will proceed to register new applicants from our waiting list.*

Cancellation Policy:

If you cancel your registration, there will be a cancellation fee.

ACD Vouchers:

While our office staff will assist you with the smooth transition of the voucher transfer, please note that it is the applicant's responsibility to make certain that the voucher is properly transferred. We therefore request that a credit card be provided on file in case the voucher does not transfer properly.

Please Note: Being that vouchers does not always cover, please make sure to speak to the office staff regarding a deposit.

Forms:

- **Registration Contract** – Fill out ONE form per family. Include all applicable price and payment information.
- **Student Information**- Fill out a *separate form for each applicant* and answer all the questions as it applies to that individual child. Preschool has a separate application.
- **Medical Form**- Fill out a separate Medical Form for each applicant, and be sure to have an original doctor's signature.

Please note: It is imperative that each child has a medical form on file. **Campers will not be allowed in on the first day of day camp without a medical form on file.**

- **Lunch Form-** Completion of this form (one per family) is mandatory *even if you are not eligible.* **Campers will not be allowed in on the first day of day camp without a lunch form on file.**

Looking forward to greeting you personally this summer *IY"H*.

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REGISTRATION CONTRACT

Family Name _____ Father's Name _____ Mother's Name _____

Address _____ City, State, Zip _____

Cross Streets _____ Home Telephone _____

Father's Business Tel._____ Mother's Business Tel. _____

Father's Cell. _____ Mother's Cell._____ Primary E-mail: **(Required)** _____

CHILDREN REGISTERED

Please refer to the supplementary fact sheet for pricing.

	Name of Child	Grade Completed Hebrew / English	Registered for: Full	1st Trip	2nd Trip	Trans.	Amount
1.	_____	____ ____	❑	❑	❑	❑	$_____
2.	_____	____ ____	❑	❑	❑	❑	$_____
3.	_____	____ ____	❑	❑	❑	❑	$_____
4.	_____	____ ____	❑	❑	❑	❑	$_____

PreN - K
Extended Hours: $25 per week_____
Trips: Full $85 Half $55_____

Total: _____

PAYMENT PLAN

❑ Voucher ❑ Check Payment *Check/post dated checks enclosed*

❑ Credit Card Payment: CC# _____ Exp. Date: ____ /____ CVC# _____

Cardholder Name: _____ Address: _____ Zip _____

Dates to Charge ___/___/___ - ___/___/___ - ___/___/___ Amounts: $_____ $_____ $_____

FOR OFFICE USE ONLY:

Date Received _____

Received By _____

❑ Student Form
❑ Medical Form
❑ Lunch Form
❑ Deposit Received
❑ Payment Plan
❑ Final Approval & Registration

EMERGENCY FORM

Please list contact other than parents.

Name: _____ Tel:_____

Cell:_____ Relationship to Camper:_____

Family Doctor: _____

Dr. Address: _____ Dr. Phone: _____

Insurance Carrier _____ Group # _____

I hereby grant permission to Machne Ohr Shraga and it's agents to take my son to his doctor or to the hospital for emergency medical treatment.

Parents Signature: _____ Date: _____ /_____ /_____

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STUDENT INFORMATION

Please complete in clear, neat print.

Name by which he/she is called_____Last name_____

Address _____ City, State, Zip _____

Home Telephone _____ Date of Birth _____

Yeshiva/playgroup attended during the year _____ Grade completed _____

Summer Program attended last year _____

Registered for: ❑ Full Season ❑ First Trip ❑ Second Trip ❑ Transportation

❑ Extended Hour: 3:30-4:30pm (Transportation can be provided)

List names of 2 boys/girls you would like you son to be with (optional)

1._____ 2._____

Please review the following questionnaire. If your answer is yes, please provide additional information below:

1. Does your child have any specific issues that we should be aware of? ❑ Yes ❑ No

_____

2. Are there any activities in which your child may not participate? ❑ Yes ❑ No

If yes, please list these activities:_____

3. Is your child on continuous medication? ❑ Yes ❑ No

Please list name(s) of medication and what we should be aware of:_____

4. Does your child have any allergies, food or medical? ❑ Yes ❑ No

Please include as much information as possible:_____

_____

Please contact our office one week before your son's attendance to review above info.

We, the parents, understand that the camp cannot be held liable for any difficulties that may arise if vital information concerning your child is not provided to the camp.

Parents Signature: _____ Date: _____ /_____ /_____

TRIP FORM

Dear Parents, We look forward to taking your child on many exciting, fun –filled trips this summer. However, we must have your consent to do so. Please sign below.

I allow my child_____ to go on camp outings. Parent's signature _____

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Dear Parents,

Here are specific instructions how to fill out the lunch form:

Part 1: ***Column 1:*** Please fill out the names of your children who are attending camp.
Column 2: If you are receiving food stamps, please indicate your **case #** (not your card #).

If you filled in a case # skip to Part 4.

Part 3: Please fill out Parents names and all childrens names in column 1. In second column write an income for husband and/or wife.

Part 4: Please **date, sign and print your name**, fill in address and phone number and the last 4 digits of your social security number.

Part 5: Check off ethnic and racial identities.

Please feel free to contact Mrs. Neumann at 718-252-7777 ext. 256 with any questions regarding filling out this form.

INCOME ELIGIBILITY FORM
FOR THE
SUMMER FOOD SERVICE PROGRAM
(For Use by Camps and Closed Enrolled Sites)

Please complete the following form using the instructions below. Sign the form and return it to: **[Name of Sponsor]** _____.

If you need help, call **[phone number of Sponsor]**

Follow these instructions, if your household gets SNAP (Food Stamps) TANF or FDPIR:

Part 1: List participant's name and a SNAP (Food Stamp), TANF or FDPIR case number.
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Sign the form. A Social Security Number is NOT required.
Part 5: Answer this question if you choose to.

If your household includes a FOSTER CHILD, use one application for the whole household and follow these instructions:

Part 1: Enter the child's name.
Part 2: Please contact us at **[phone number of Sponsor]**
Part 3: Complete this part if you are applying for other children in the household and you did not enter a SNAP (Food Stamp), TANF or FDPIR case number in Part 1.
Part 4: Sign the form. If Part 3 was completed, provide the last four digits of the signing adult's Social Security Number.
Part 5: Answer this question if you choose to.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: List each participant's name.
Part 2: Skip this part.
Part 3: Follow these instructions to report total household income from last month.

Column A–Name: List the first and last name of **each** person living in your household, related or not (such as grandparents, other relatives, or friends who live with you). You must include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B–Gross income last month and how often it was received. Next to each person's name, list each type of income received last month, and how often it was received.

In Box 1, list the **gross income** each person earned from work. This is not the same as take-home pay. **Gross income is the amount earned before taxes and other deductions.** The amount should be listed on your pay stub, or your boss can tell you. Next to the amount, write how often the person got it (weekly, every other week, twice a month, or monthly).

In box 2, list the amount each person got last month from welfare, child support, alimony.

In box 3, list Social Security, pensions, and retirement.

In box 4, list ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits, regular contributions from people who do not live in your household. Report net income for self-owned business, farm, or rental income. Next to the amount, write how often the person got it. If you are in the Military Housing Privatization Initiative do not include this housing allowance.

Column C–Check if no income: If the person does not have any income, check the box.

Part 4: An adult household member must sign the form and include the last four digits of his or her Social Security Number, or mark the box if he or she doesn't have one.
Part 5: Answer this question if you choose to.

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a SNAP, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Part 1. Children enrolled in Camp or Closed Enrolled Sites.

Names (First, Middle Initial, Last)	SNAP (Food Stamp), TANF or FDPIR case # (if any). **Skip to Part 4 if you listed a case #.**

Part 2. Foster Child

Foster children eligible for free and reduced-price meals regardless of household income. If a foster child lives with you, please contact **[name of Sponsor]** at **[phone number]**. Complete Part 3 if you are applying for other children in your household and you did not enter a SNAP (Food Stamp), TANF or FDPIR case number in Part 1.

Part 3. Total Household Gross Income—You must tell us how much and how often

A. Name (List **everyone** in household, including children)	**B. Gross income and how often it was received** *Example: $100/monthly $100/twice a month $100/every other week $100/weekly*				**C. Check if NO income**
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Social Security, pensions, retirement,	4. All Other Income	
1.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	❑
2.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	❑
3.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	❑
4.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	❑
5.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	❑
6.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	❑
7.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	❑
8.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	❑
9.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	❑
10.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	❑
11.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	❑
12.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	❑

Part 4. Signature and Social Security Number (Adult must sign)

An adult household member must sign this form. If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that this information is being given for the receipt of Federal funds. I understand that SFSP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: X_____Print name:_____Date: _____
Address:_____Phone Number:_____
Last four digits of Social Security Number: __ __ __ __ ❑ I do not have a Social Security Number

Part 5. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ Asian ❑ White ❑ Black or African American	❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12
Total Income: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year
Household size: _____
Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free___ Reduced___ Denied___
Reason: _____
Determining Official's Signature: _____ Date: _____
Confirming Official's Signature: _____ Date: _____
Follow-up Official's Signature: _____ Date:_____

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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	Date of Birth (Month/Day/Year)
			☐ Female ☐ Male	___/___/___

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

City/Borough	State	Zip Code	School/Center/Camp Name	District ___ Number ___	Phone Numbers
					Home _____ Cell _____ Work _____

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

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

Attach MAF in in-school medications needed

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

☐ Asthma ***(check severity and attach MAF)***: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes ***(attach MAF)***
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) _____
Explain all checked items above.
☐ ***Addendum attached.***

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

PHYSICAL EXAM Date of Exam: ___/___/___

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

General Appearance:

☐ Physical Exam WNL

	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	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Hepatitis B	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Measles	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Mumps	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Rubella	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Varicella	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Polio 1	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Polio 2	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Polio 3	___/___/___

MMR	___/___/___	___/___/___	___/___/___
Varicella	___/___/___	___/___/___	___/___/___
Mening ACWY	___/___/___	___/___/___	___/___/___
Hep A	___/___/___	___/___/___	___/___/___
Rotavirus	___/___/___	___/___/___	___/___/___
Mening B	___/___/___	___/___/___	___/___/___

Tdap	___/___/___	___/___/___	___/___/___
Other _____	___/___/___	_____	___/___/___

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

Facility Name

National Provider Identifier (NPI)

Address City State Zip

Telephone Fax Email

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

Comments:

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

REVIEWER:

FORM ID#