2324 West 13th Street
Brooklyn, NY 11223

Please Attach Current Photo

Sunday/ School Holiday Program Application

Date: ______________

First Name: ______________________________ Last Name: _____________________________

Date of Birth:____/____/____ Age:_____ Last Weight:________

Address: ____ Cross Streets: __________________

City: _______________________ State: ______ Zip Code____________

Home Phone #: (______)_____-_______.

Parent's Marital Status: (circle) Married Divorced Single Widowed

Mother's Name: ________________________ Mother's Cell Phone # :(______)______-__________

Mother's Occupation: ____________________ Mother's Work Phone # :(_____)______-______

Mother's Email: ____

Father's Name: ________________________ Father's Cell Phone # :(______)______-__________

Father's Occupation: ____________________ Father's Work Phone # :(______)______-______

Father's Email: ____

Emergency Contacts:

1. Name: ________________________ Phone # :(_____)_____-__________

   Address: ____

   Relationship to Child: ____

2. Name: ________________________ Phone # :(_____)_____-__________

   Address: ____

   Relationship to Child: ____

3. Name: ________________________ Phone # :(____) ___-______

Address: ____

Relationship to Child: ____

If emergency contacts are not available appropriate measures will be taken.

Doctor's Name: ____________________________ Phone Number: (____) ___-__________

Address:____

Other Specialist Name: _________________________ Phone Number: (____) ___-__________

Address:____

Child's Medicaid #:_____________________________ Child's SS #:__________________________

Health Insurance (other than Medicaid): ____

Policy #:___________________________________ Policy in name of: _________________________

Child's Diagnosis: ____

Functioning Level: (circle) Mild Moderate Severe Profound

Please check all disabilities that apply;

___Mental Retardation

___Epilepsy

___Autism

___PDD

___Down Syndrome

___Cerebral Palsy

___Deaf

___Hearing Impaired

___Vision Impaired

___Mobility Impaired

___Blind

___Other:__________________________

What School Program does your child attend? ______________________________________

Address: ____

Contact Person: ___________________________Phone Number: # :(____) ___-______

Does your child have a medical condition for which he/she is being treated? ___ Yes ___ No

If yes, please list the condition and medication taken:

1. Condition: ____________________ Medication/ Dosage: _______________________________
2. Condition: ____________________ Medication/ Dosage: _______________________________
3. Condition: ____________________ Medication/ Dosage: _______________________________

Does your child take his/her own medication? ___ No ___ Yes

Does your child have seizures? ___ No ___ Yes

If yes, what procedure should be followed?

____

____

List any allergies your child has: ____

Is your child toilet trained? ___ No ___ Yes

If yes, how much assistance do they need? ____

How does your child indicate the need to use the bathroom?

____

How does your child behave in a new environment?

____

____

What method works best in calming your child?

____

Please list some of your child's favorite activities:

____

If your child engages in any of the following activities please describe the behavior and circumstances:

1. Self-injurious behavior:

____

2. Injurious to others:

____

3. Self-stimulating behavior:

____

How does your child communicate? ___ Verbally ___ Sign Language ___ Communication Board

What language(s) does your child speak and understand? ________________________________

How much and what kind of assistance, if any, does your child need during mealtimes?

____

Is your child on a special diet? ___ No ___ Yes

If yes, please specify:

____

____

Is there any behavior we should be aware of during feeding time? Please specify:

____

____

Is your child enrolled in Medicaid Waiver: ___Yes ___No

Service Coordinator: ________________________ Phone # :(____) ______ - ________ Ext.______

Agency: ____

Address: ____