The Children's Aid Society
Rhinelander Children's Center
Saturday Program for Deaf and Hard of Hearing Children & Teens
350 East 88th Street New York, NY 10128
TELEPHONE: (212) 876-0500 FAX: (212) 876-9718
www.rhinelandercenter.org

Dear Friends:

The Rhinelander Center's Saturday Program for Deaf and Hard of Hearing Children & Teens is now accepting applications for the 2011-2012 school year.

The program is ***FREE*** and offered to Deaf and Hard of Hearing young people between the ages of 5-20. The program meets twice a month from 10:00am to 3:00pm. Parents are responsible for bringing their children to the center and picking them up at the close of the session. The program is split up into two groups. The Children's Program consists of youngsters between the ages of 5-13 in elementary and junior high school. The Teen Program consists of young adults between the ages of 14-20 and is solely for students in high school and beyond. Children must bring lunch from home. Teens can bring lunch from home or money to purchase lunch; however, lunch from home is mandatory on trip days.

Children participate in a variety of activities including: arts & crafts, dance, drama, cooking, group games, educational workshops, and free play. Teens are involved with peer intervention workshops, dance lessons, sports, and community service projects. One Saturday each month, children and teens enjoy field trips to cultural and recreational activities, including: bowling, miniature-golf, apple picking, ASL interpreted theater performances, museum visits, sporting events and much, much more. Sign language classes and parent workshops are also offered to family members. In addition, Deaf professionals are often invited to speak with the children/teens.

Our staff consists of Deaf and hearing individuals experienced in working with our population. They are proficient in the various modalities which our participants use to communicate, whether it is American Sign Language or spoken English. Each child's mode of communication is celebrated and recognized here.

If you have any questions please feel free to e-mail Jackie Kimball at jacquelinek@childrensaidsociety.org or call us at (212) 876-0500 (v). If interested in enrolling your child please complete the attached application form and health record and return them to:

SATURDAY PROGRAM
Rhinelander Center
350 East 88th Street
New York, NY, 10128
or Fax: 212-876-9718

Newcomers to the program may be interviewed by a senior staff member or participate on a trial basis for one or two sessions to ensure a good fit. We look forward to seeing our old members and meeting new members for another exciting year.

Sincerely,

Jackie Kimball
Program Coordinator

The Children's Aid Society
Rhinelander Children's Center
Programa de los Sábados Para Niños Sordos y Adolescentes Con Limitaciones Auditivas
350 East 88th Street New York, NY 10128
Phone: (212) 876-0500 Fax: (212) 876-9718
www.rhinelandercenter.org

Estimados Amigos:

Children's Aid Society ubicado en el Rhinelander Center le agrada informarle la continuación del Programa de los Sábados Para Niños Sordos y Con Limitaciones Auditivas. Están aceptando aplicaciones para el ano del 2011-12.

El programa se le ofrece a los niños sordos y con limitaciones auditivas sin impedimentos severos secundarios, entre las edades de 5-20 años. El programa se llevara acabo dos Sábados al mes (las fechas serán anunciadas) de 10:00am a 3:00pm. El programa de los Sábados es ***GRATIS***! (sin costo alguno a usted) para todos los niños y las familias aceptados al programa. ****FAVOR DE NOTAR: Los padres son responsables por el trasporte de ida y vuelta al programa y por proveerle Almuerzo a sus hijos/as.*** Los niños de (5-13 años) favor de traer un almuerzo preparad. Los adolescentes de (14-20 años) favor de traer almuerzo o dinero para salir a comprar lo que desean comer.

Un sábado al mes los niños asistirán paseos tales como, patinando, obras del teatro realizadas en el lenguaje de señales, el circo, la bolera y mucho más! Además celebramos fiestas anuales y terminamos con una barbacoa al fin del año. El otro sábado al mes los niños se quedaran en el centro y participaran en actividades de arte, actuaciones, juegos en grupos y baile.

Todo el personal tiene facilidad en American Sign Language (Lenguaje de Señales Americanas) Este programa único le ofrece experiencias creativas a los niños y le da la oportunidad de conocer nuevos amigos. Además, las familias pueden participar en clases de señas mensuales y en varios talleres.

Si usted tiene alguna pregunta favor de comunicarse por correo electrónico con Jackie Kimball en jacquelinek@childrensaidsociety.org o llámenos al (212) 876-0500 (v). Si está interesado en inscribir a su niño/a, favor llenar la aplicación con el registro de salud y devolverlos a:

PROGRAMA DE LOS SÁBADOS
Rhinelander Children's Center
350 East 88th Street
New York, NY 10128
or Fax: 212-876-9718

Los recién llegados a este programa pueden ser entrevistados por un funcionario superior o participar en un régimen de prueba durante una o dos sesiones para garantizar un buen ajuste. Esperamos ver a nuestras amistades viejas y nuevas para otro año emocionante.

Atentamente,

Jackie Kimball
Coordinador del Programa

The Children's Aid Society
Rhinelander Children's Center
350 East 88th Street- New York, NY 10128
(212) 876-0500 Fax (212) 876-9718
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Information Form for Saturday Program 2011-2012

Child's Name:____Date of Birth:___________________

School: ____Grade:____________Age:_______________

Please indicate any disabilities in addition to deaf or hard of hearing: _______________________________

____

Parent/Legal Guardian Information:

Mother's Name: ___________________________Father's Name: _________________________________

Address:____ Apt #: _______

City: ____State: __________ Zip Code:___________________

Home phone #: ____

Mother's cell phone #: ___________________________ Father's cell phone #:_______________________

E-Mail: ____

Child/Teen's Email:____

Alternate # where parents can be reached on Saturdays:____

My child may also be picked up by:

Name: ____ Relationship: ________________________

Phone #:_____________________________

Name: ____ Relationship: ________________________

Phone #:_____________________________

Sibling:____________________________Age:_________School: ___________________________________

Sibling:____________________________Age:_________School: ___________________________________

Sibling:____________________________Age:_________School: ___________________________________

Emergency Contact Information: (other than parents)

Name: __________________________ Relationship: ___________ Phone #:_________________________

Name: __________________________ Relationship: ___________ Phone #:_________________________

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Formulario de Información del Programa de los Sábados 2011-2012

Nombre del niño: ________________________________ Fecha de Nacimiento: _______________

Escuela: __________________________________ Grado: __________ Edad: _______________

Por favor, indique algún tipo de discapacidad, además de personas sordas o con dificultades auditivas:

____

Información del Padre / Tutor Legal:

Nombre de la Madre: _________________________ Nombre del Padre: ______________

Dirección: ____ Aptó#: _____________

Cuidad: __________________________________Estado: __________ Código Postal:______________

Teléfono de la casa #: ____________________________

Teléfono celular de la madre #: _____________________Teléfono celular del padre #:_______________

Correo electrónico: ____

Correo electrónico del niño/adolescente:____

Numero alternativo donde nos podemos comunicar con los padres los Sábados:

____

Mi niño también puede ser recogido por:

Nombre: ____ Relación: _______________________

Número de Teléfono #:____________________________

Nombre: ____ Relación: _______________________

Número de Teléfono #:____________________________

Hermano/a:______________________________Edad:_______________Escuela:____________________

Hermano/a:______________________________Edad:_______________Escuela :____________________

Hermano/a:______________________________Edad:_______________Escuela:____________________

Información de contacto de emergencia: (aparte de los padres)

Nombre: _________________________ Relación: ___________ Número de teléfono #:______________

Nombre: _________________________ Relación: ___________ Número de teléfono #:______________

Medical Information

Child's Doctor:________________________________Phone #:_______________________________

Medical Insurance Name & Policy #:____

List any outstanding physical characteristics:____

Does your child take any medications? Yes__________No___________

Medication:________________________ When taken: ________________________________

Reason: ____

Are there any specific food allergies or dietary restrictions? Yes_________No___________

If yes, please explain: ____

Are there any sports or other activity restrictions? Yes_________No___________

If yes, please explain: ____

Social Information

What languages are spoken at home? ____

Does child's family know sign language? ____

Does your child have any specific fears? ____

What are your child's strengths? ____

What activities does your child enjoy? ____

Does your child have any difficulties in social situations?______________________________________

____

What do you hope your child will gain from his/her Saturday Program experience?

____

____

I, ______________________________________, hereby consent that photographs and videos can be taken of my child and used in school projects, newsletters, news releases, the Rhinelander website, and the Rhinelander Facebook page for community members.

________________________________ ________________________________

Signature Date

____

Relationship to child

Información Médica

Médico del Niño:__________________________Número de teléfono #:____________________________

Nombre del seguro médico y Póliza #:____

Haga una lista de características físicas sobresalientes:____

Su niño toma algún medicamento? Sí ___________No __________

Medicamento: ________________________ Cuando se toma: ___________________

Razón: ____

Hay alguna alergia a alimentos específicos o restricciones en la dieta? Sí__________No___________

En caso afirmativo, por favor explique: ____

Hay algún deporte u otras restricciones de actividades? Sí __________No __________

En caso afirmativo, por favor explique:____

Información Social

Qué idiomas se hablan en el hogar? ____

La familia del niño sabe lenguaje de señas? ____

Su niño tiene algún miedo específico? ____

Cuáles son los puntos fuertes de su niño? _______________________________________

Qué actividades su niño disfruta? ____

Su niño tiene dificultades en situaciones sociales? ______________________________________

____

Que usted espera que su niño se beneficiará de su experiencia del Programa de los Sábados?

____

____

Yo, ____, doy consentimiento que fotografías y vídeos pueden ser tomadas de mi niño y utilizar en proyectos escolares, boletines, comunicados de prensa, el website de Rhinelander y la página de Facebook de Rhinelander para miembros de la comunidad.

__________________________________ ___________________________________
Firma Fecha

____
Relación al niño

FAX #: 212-876-9718

CHILD & ADOLESCENT HEALTH EXAMINATION FORM
Please Print Clearly Press Hard

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

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 corticosteroid ☐ 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 ____ %

	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)*	__/__/__	☐ 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

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:

CH-205 (5/08) *Copies:* **White** School/Child Care/Early Intervention/Camp, **Canary** Health Care Provider, **Pink** Parent/Guardian

Authorization for Medical Treatment
(Standing Order)

Child's Name:______________________________ D/O/B:__/___/___

I, (Physician's Name) ______________________________authorize for my patient

(Child's Name)_____________________________, to receive the following

medications/treatments while attending Wagon Road camp.

Medication/Treatment	**Approval (Circle yes or No)**	
For fever/pain:		
Tylenol	Yes	No
Motrin	Yes	No
For minor abdominal discomfort:		
Pepto-Bismol	Yes	No
Mylanta	Yes	No
Tums	Yes	No
For minor skin injury:		
Topical antibiotic ointment	Yes	No
For constipation:		
* Will only be given if no bowel movement for 3 days and abdominal discomfort:		
Milk of Magnesia	*Yes*	*No*
For allergic reaction:		
Calamine lotion	*Yes*	*No*
Benadryl	*Yes*	*No*
For minor cough:		
Cough Syrup	*Yes*	*No*
For difficulty breathing:		
Albuterol per nebulizer	*Yes*	*No*

Physicians Signature:___________________________________ Date:___/___/___

Parents Signature:_____________________________________Date:___/___/___

MUST BE SIGNED BY PARENT/DOCTOR!!

Autorización para tratamiento medico

Nombre del niño/a:________________________________Fecha de Nacimiento:__/___/___

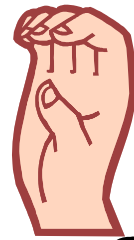
Yo, (Nombre del Medico) ________________________________autorizó que mi paciente

(Nombre del niño/a)__________________________, que reciba los medicamentos/tratamientos cuando este en el campo de Wagon Road.

Medicamento/Tratamiento	**Aprobado (Indique sí o no)**	
<u>Para fiebre/dolor:</u>		
Tylenol	Si	No
Motrin	Si	No
<u>Para el dolor de estomagó</u>:		
Pepto-Bismol	Si	No
Mylanta	Si	No
Tums	Si	No
<u>Para la piel:</u>		
Ungüento de antibióticos	Si	No
<u>Para la constipación:</u>		
*Solamente se le dará al niño/a si no usado el baño mas de tres días:		
Leche de Magnesia	Si	No
<u>Para reacciones alérgicas:</u>		
Loción Calamina	Si	No
Benadryl	Si	No
<u>Para la toz:</u>		
Medicina para la tos	Si	No
<u>Para dificultades respiratorias:</u>		
Albuterol (Pompa de asma)	Si	No

Firma del Medico:________________________________ Fecha:___/___/___

Firma del pariente:_______________________________Fecha:___/___/___



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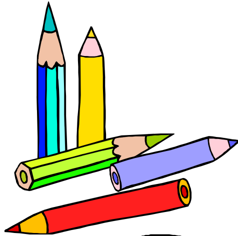
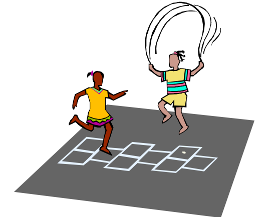
SATURDAY PROGRAM FOR DEAF
& HARD OF HEARING CHILDREN & TEENS

PROGRAM DATES 2011-2012

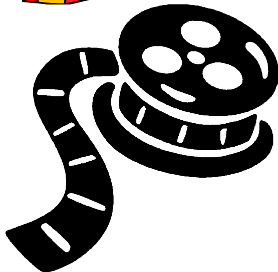
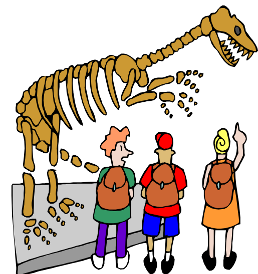
SEPTEMBER 10th & 17th

OCTOBER 15th & 29th

NOVEMBER 5th & 19th

DECEMBER 3rd & 10th

JANUARY 7th & 21st

FEBRUARY 4th & 11th

MARCH 3rd & 24th

APRIL 21st & 28th

MAY 12th & 19th

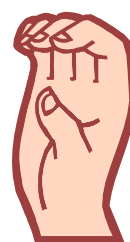
JUNE 9th & 16th

PROGRAM TIMES
10:00-3:00 PM

CHILDREN IN GROUPS 1, 2, & 3 **MUST**
ALWAYS BRING LUNCH

TEENS IN THE TEEN GROUP ARE
ENCOURAGED TO ALWAYS BRING LUNCH
FROM HOME.
LUNCH FROM HOME ON TRIP DAYS IS
MANDATORY!

PICK-UP IS AT 3:00 PM PROMPTLY!



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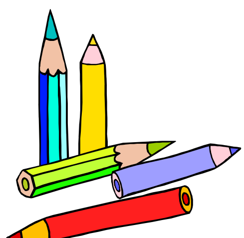
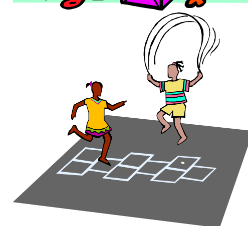
Programa de los Sábados Para Niños Sordos y Adolescentes Con Limitaciones Auditivas

DÍAS DEL PROGRAMA
2011-12

SEPTIEMBRE 10 & 17

OCTUBRE 15 & 29

NOVIEMBRE 5 & 19

DICIEMBRE 3 & 10

ENERO 7 & 21

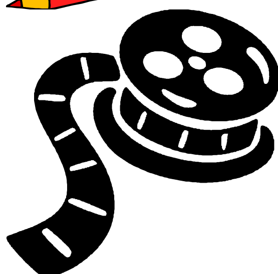
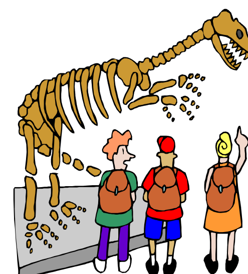
FEBRERO 4 & 11

MARZO 3 & 24

ABRIL 21 & 28

MAYO 12 & 19

JUNIO 9 & 16

HORAS DEL PROGRAMA
10:00-3:00 PM

NIÑOS EN LOS GRUPOS 1, 2, Y 3 **SIEMPRE** DEBEN TRAER SU ALMUERZO

ADOLESCENTES EN EL GRUPO DE ADOLESCENTES SE RECOMIENDA QUE SIEMPRE TRAIGAN ALMUERZO DE SU CASA

*TRAER ALMUERZO DE SU CASA EN DÍAS DE VIAJES ES **MANDATARIO!***

FAVOR DE RECOGER SUS NIÑOS A LAS 3 PM