SWAN – The Shuang Wen Academy Network
2019-2020 Preschool Enrollment Form
90 Bowery Street, 2nd Floor, NY, NY 10013
Tel: 646-998-5786 Email: Info@swan-nyc.org

For Office Use Only

Date received: _____
Received by: _____

Form Updated 12.19

2020 – 2021 School Year

Student Name: _____Chinese Name:_____

Date of Birth: _____/_____/_____

Are you a current SWAN student? ☐ Yes _____ ☐ No. Current School:_____

2s & 3s ONLY. Preferred Start Date: _____

Parent/Guardian Information (Please Print) ( ) Mother ( ) Father ( ) Legal Guardian

First Name:_____ Last Name:_____

Street Address:_____ Apt.: _____ City:_____

State:_____ Zip Code:_____ Home Phone: (_____)_____

Email:_____ Mobile Phone: (_____)_____

How did you hear about us? ☐ Referral ☐ Website ☐ Flyer

Registration Information

- **Payment Option**: - Check: Payable to ***SWAN*** (Include **student's name** on check). Online Payment: Contact info@swan-nyc.org or 646.998.5786.
- **Payment Policy**: After the first month tuition, monthly tuition is due on every 15th of the month before the next month, grace period of 5 days before late fee of $35 is applied. Upon acceptance a $325 non-refundable deposit is required to guarantee your child's seat ($100 for registration fee and $225 deposit applies to last month of tuition with seven-week written withdrawal notice).
- **Bounced Check Fee**: A $35 bank fee for each bounced check.
- **Absent and Vacation**: There is no refund/proration on absenteeism, vacation, and/or school closure.
- **Withdrawal**: Seven-week written notice to info@swan-nyc.org is required to receive the $225 deposit. Withdrawal notice submitted less than seven-week will forfeit the $225 deposit. Child's last month of tuition is "not" prorated.

By signing this Form I confirm that all information entered on this form submitted by me is authentic. I also agree to the payment, refund and withdrawal policy above. And I understand default on payment will cause suspension of service immediately.

Signature: _____ (Parent/Guardian) Date:_____

swan
雙文教育系統
The Shuang Wen Academy Network

2020 – 2021 School Year

Deposit/Tuition is Required to Secure a Seat

Two Year Old Tuition **Born 2017**	**Three Year Old Tuition** **Born 2016**	**Pre-Kindergarten Tuition** **Born 2015**
8:30am to 6pm – Full Day ☐ $1,700	**8:30am to 6pm Full Day** ☐ $1,500	**8:30am to 6:00pm** ☐ Medium Income: $1,000 *Below $200K household income of 3 is considered medium income. Income verification required. ☐ Regular Income: $1,335 *Above $200K for a household income of 3 is considered regular income.
REGISTRATION FEE & DEPOSIT ☐ $100 (One Time Registration Fee) ☐ $225 (Deposit for Last Month Tuition)	**REGISTRATION FEE & DEPOSIT** ☐ $100 (One Time Registration Fee). New Student Only. ☐ $225 (Deposit for Last Month Tuition)	**REGISTRATION FEE & DEPOSIT** ☐ $100 (One Time Registration Fee). New Student Only. ☐ $225 (Deposit for Last Month Tuition)
Extended Care ☐ 6:00pm to 6:30pm $355	**Extended Care** ☐ 6:00pm to 6:30pm $355	**Extended Care** ☐ 6:00pm to 6:30pm $355
Grand Total: _____	**Grand Total: _____**	**Grand Total: _____**

Registration Information

- **Payment Option**: - Check: Payable to ***SWAN*** (Include **student's name** on check). Online Payment: Contact info@swan-nyc.org or 646.998.5786.
- **Payment Policy**: After the first month tuition, monthly tuition is due on every 15th of the month before the next month, grace period of 5 days before late fee of $35 is applied. Upon acceptance a $325 non-refundable deposit is required to guarantee your child's seat ($100 for registration fee and $225 deposit applies to last month of tuition with seven-week written withdrawal notice).
- **Bounced Check Fee**: A $35 bank fee for each bounced check.
- **Absent and Vacation**: There is no refund/proration on absenteeism, vacation, and/or school closure.
- **Withdrawal**: Seven-week written notice to info@swan-nyc.org is required to receive the $225 deposit. Withdrawal notice submitted less than seven-week will forfeit the $225 deposit. Child's last month of tuition is "not" prorated.

2019 – 2020 Student Information Form
2019 - 2020 學生信息表

swan 雙文教育系統 The Shuang Wen Academy Network

Participant Information 參加學生資料

1.Last Name 姓:_____ First Name 名:_____

2.Gender 性別:☐Male 男生 ☐Female 女生

3.Birth Date 出生日期: _____

4.Ethnicity 種族:☐ American Indian 美國印地安人 ☐ Asian 亞裔 ☐ African American 非裔 ☐ Hispanic 西語裔
☐ Pacific Islander 太平洋島國 ☐ White 白人 ☐ Other 其他

5.Emergency Contact Name 緊急聯係人:

1) Last Name 姓:_____ First Name 名:_____ Home Phone Number 家裡電話: _____ Cell Phone Number 手機電話: _____ Relationship to applicant 和申請者關係: _____	2) Last Name 姓:_____ First Name 名:_____ Home Phone Number 家裡電話: _____ Cell Phone Number 手機電話: _____ Relationship to applicant 和申請者關係: _____

6. Primary Language 主要使用語言: ☐ Mandarin 普通話 ☐ Cantonese 廣東話 ☐ English 英文
☐ Other 其他: _____

7. Do you have other children registered in this program 您有其他的孩子參加這個課後班嗎?
☐Yes 是 ☐No 否
If yes, please list additional children below 若有的話，請將其他孩子的姓名寫在下面:
Last Name 姓:_____ First Name 名:_____
Last Name 姓:_____ First Name 名:_____

Pick-Up Permissions 接送許可

☐ I give permission for my child to go home alone at dismissal.我允許我的孩子在放學時自行回家

Child may be picked up by 下列人士可以接我的孩子:

1) Last Name 姓:_____ First Name 名:_____
Home Phone Number 家裡電話:_____
Cell Phone Number 手機電話:_____
Relationship to applicant 和申請者關係:_____

2) Last Name 姓:_____ First Name 名:_____
Home Phone Number 家裡電話:_____
Cell Phone Number 手機電話:_____
Relationship to applicant 和申請者關係:_____

Child may not be picked up by 下列人士不可以接我的孩子:

1) Last Name 姓:_____ First Name 名:_____
Relationship to applicant 和申請者關係:_____

2) Last Name 姓:_____ First Name 名:_____
Relationship to applicant 和申請者關係:_____

Health Information 健康訊息

Please check any box that applies to your child 請勾選您的孩子適用的選項:

Allergies to food 食物過敏: ☐Yes 是 ☐No 否

If yes, please specify 若有的話，請說明:_____

Allergies to medicine 藥物過敏: ☐Yes 是 ☐No 否

If yes, please specify 若有的話，請說明:_____

Allergies other 其他過敏: ☐Yes 是 ☐No 否

If yes, please specify 若有的話，請說明:_____

Asthma 哮喘: ☐Yes 是 ☐No 否

Behavioral/Emotional issues 行為/情緒問題: ☐Yes 是 ☐No 否

Convulsions/Seizures 抽搐/癲癇: ☐Yes 是 ☐No 否

Corrective Device (glasses, hearing aid, etc.)矯正用具(眼鏡、助聽器等): ☐Yes 是 ☐No 否

Diabetes 糖尿病: ☐Yes 是 ☐No 否

Individualized Education Plan 個別特殊教育計畫: ☐Yes 是 ☐No 否

Physical Disabilities 身體殘障: ☐Yes 是 ☐No 否

Other (please specify)其他(請說明):_____

Children who have special health care needs are those who have chronic physical, developmental, behavioral, or emotional conditions expected to last 12 months or more and who also require health and related services of a type beyond that are required by children generally. If you child does have special health care needs please discuss these with your child care provider.有特殊醫療需求的兒童是指患有可能持續十二個月以上的身體、發展、行為、或情緒方面的慢性疾病，其所需的醫療相關服務已超越一般兒童的需求。若您的孩子需要特殊醫療照護，請告知您孩子的托育單位。

Please explain 請說明:_____

_____

Does your child have special health care needs that require treatment and/or medication 您的孩子是否需要治療和(或)藥物方面的特殊醫療照護? ☐Yes 是 ☐No 否

Please explain 請說明:_____

_____

Does your child take medication for any condition or illness 您的孩子是否服用治療疾病的藥物? ☐Yes 是 ☐No 否

Please explain 請說明:_____

_____

Are there any activities your child cannot participate in 您的孩子是否無法參加某些活動? ☐Yes 是 ☐No 否

Please explain 請說明:_____

_____

CERTIFICATION STATEMENT 保證聲明

I, the undersigned, certify that all information on this form is true and correct. I understand that my statements are subject to verification. I agree and accept that I will abide by all applicable rules and regulations of this program. I consent to the enrollment and participant of the child listed above in this program. 我證實此申請表中的所有資料正確無誤，我了解我的聲明將受到驗證。我同意並接受此課後班所有相關的法令規章，我同意我的孩子報名參加此課後班。

☐ **Checking this box indicates that Shuang Wen Academy Network (SWAN) has permission to contact me regarding notifications, information and news regarding Shuang Wen Academy Network (SWAN) policies, scholarships, events, programs and affiliates. 我同意雙文教育系統將雙文教育系統政策、獎學金、活動、課程、以及下屬單位相關的通知、訊息、以及新聞寄給我。**

Parent Name (Please Print) 家長姓名（請書寫）: _____

Parent/Guardian Signature 家長/監護人簽名: _____Date 日期:_____

2019 – 2020 PRE-SCHOOL

CONSENT FORM

PHOTO/VIDEO/INTERVIEW CONSENT (To be completed by the parent or guardian)

I certify that I am the parent or legal guardian of _____, whose date of birth is _____.
Name of child
Month/day/year

I understand that this summer program features special events both in-school and away from school. Media representatives, newspaper and television reporters, photographers, and public-relations personnel may be present at these special events to record them. In some cases they may interview and/or photograph children who participate in these events. These photographs, videos, and interviews will only be used to promote this after-school program.

I give permission for my child to be photographed or otherwise recorded during summer program events and activities, and for any and all such photographs to be displayed by Shuang Wen Academy Network--SWAN, whether now or hereafter known or developed.

SIGNATURE OF PARENT OR GUARDIAN DATE

PARENT NAME (PLEASE PRINT)

If you do not wish for your child to participate in the activities described above, please review this section of this form.

I **DO NOT** give permission for my child to be photographed or otherwise recorded during summer program events and activities. As a result, my child may not be able to participate in these events and activities.

SIGNATURE OF PARENT OR GUARDIAN DATE

swan
雙文教育系統
The Shuang Wen Academy Network

My Portfolio
關 於 我

My name is 我的名字是	I am a 我是 ☐ Boy 男生 ☐ Girl 女生
My birthday is 我的生日是 / /	The language(s) I speak at home is 我講
Please circle: I am the only child or I have younger or older sibiling(s) 請圈：我是 唯一的孩子 或 我有 比我小 或 比我大兄弟姐妹）	My favorite song is 我最愛的歌曲是
My favorite and Least favorite food is 我最愛的食物是	My favorite toy is 我最愛的玩具是
My favorite color is 我最愛的顏色是	I always nap in the afternoon 我喜歡午睡 ☐ Yes 是 ☐ No 不是
My Favorite Sleeping Position Is 我喜歡的睡覺方式是	☐ Facing Ceiling 躺著睡 ☐ Facing Bed 趴著睡 ☐ Facing Left 朝左睡 ☐ Facing Right 朝右睡
I am allergic to: 我有過敏症(請列出):	

Updated 122019

swan
Chinese-American International School
展望中美國際學校
A Program of Shuang Wen Academy Network

SWAN Preschool
2019 - 2020 Meal Form

SWAN is working with Red Rabbit to provide meals for our students. Their made-from-scratch meals are prepared fresh in the kitchen every day. Red Rabbit is "Child and Adult Care Food Program (CACFP) compliant", providing great-tasting, kid-tested food that is free of preservatives or artificial flavorings. You can visit the website (www.myredrabbit.com) for sample menu and more information.
SWAN is a nut free environment. We provide a nut free menu.

Student Name: _____ Date of Birth: _____

Program (Please circle):

Full Day 4s – Breakfast and Lunch Included

Full Day 3s – Breakfast and Lunch Included

Full Day 2s - Breakfast and Lunch Included

Snack is not included. Remember to have your child brings his/her own water bottle and an extra bottle for milk (especially for the 2s).

Food Allergy (Please specify the intensity):

☐ My child **WILL NOT** be receiving meal service at SWAN. I am will be responsible to prepare my own meal (please circle): Breakfast Lunch
Parent's Initial: _____

Parent Name: _____ Parent Signature: _____

Today's Date:_____

swan
雙文教育系統
The Shuang Wen
Academy Network

SWAN Preschool

Emergency Treatment Consent Form

As parent/guardian, I hereby give consent to SWAN Preschool (The Shuang Wen Academy Network) to provide all emergency care to_____ (Child's name) in the event that the child requires medical attention while participating SWAN Preschool.

- I understand all efforts will be made to contact me prior to treatment. In the event that I cannot be reached, I will give permission to the attending physician to treat my child.
- I understand and acknowledge that I am responsible for all reasonable charges in connection with transportation, care and treatment given.
- I understand that SWAN will not be responsible for anything that may happen as a result of false/missing information given at the time of enrollment.

I hereby waive, release, hold harmless and forever legal discharge against SWAN Preschool, its employees, agents, officers, volunteers, directors, board, or representatives from any and all claims, damages, or liability arising in law or equity as a result of SWAN Preschool's administration of medical treatment in conformance with the authorization provided.

_____

Child's Name Date of Birth

_____

Parent/Guardian's Print Name

_____

Parent/Guardian Signature Today's Date

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly Press Hard

STUDENT ID NUMBER OSIS

TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | **Sex** ☐ Female ☐ Male | **Date of Birth** *(Month/Day/Year)* __ __ / __ __ / __ __ __ __

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

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

Health insurance (including Medicaid)? ☐ Yes ☐ No | ☐ **Parent/Guardian** Last Name | First Name | ☐ **Foster Parent**

TO BE COMPLETED BY HEALTH CARE PROVIDER *If "yes" to any item, please explain (attach addendum, if needed)*

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

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

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

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

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

Explain all checked items above or on addendum

Medications *(attach MAF if in-school medication needed)*

☐ None ☐ Yes *(list below)*

_____

_____

Dietary Restrictions

☐ None ☐ Yes *(list below)*

_____

PHYSICAL EXAMINATION

Height _____ **cm** (__ __ %ile)

Weight _____ **kg** (__ __ %ile)

BMI _____ **kg/m²** (__ __ %ile)

Head Circumference *(age ≤2 yrs)* _____ **cm** (__ __ %ile)

Blood Pressure *(age ≥3 yrs)* _____ / _____

General Appearance:

	NI	Abnl		NI	Abnl		NI	Abnl		NI	Abnl		NI	Abnl
☐	☐	HEENT	☐	☐	Lymph nodes	☐	☐	Abdomen	☐	☐	Skin	☐	☐	Psychosocial Development
☐	☐	Dental	☐	☐	Lungs	☐	☐	Genitourinary	☐	☐	Neurological	☐	☐	Language
☐	☐	Neck	☐	☐	Cardiovascular	☐	☐	Extremities	☐	☐	Back/spine	☐	☐	Behavioral

Describe abnormalities:

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

If delay suspected, specify below

☐ Cognitive *(e.g., play skills)* _____

☐ Communication/Language _____

☐ Social/Emotional _____

☐ Adaptive/Self-Help _____

☐ Motor _____

SCREENING TESTS	*Date Done*	*Results*
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	__/__/__	_____ µg/dL
	__/__/__	_____ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	__/__/__	☐ At risk *(do BLL)* ☐ Not at risk
Hearing ☐ Pure tone audiometry ☐ OAE	__/__/__	☐ Normal ☐ Abnormal
Head Start Only		
Hemoglobin or Hematocrit *(age 9–12 mo)*	__/__/__	_____ g/dL _____ %

	Date Done	*Results*
Tuberculosis *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school*		
PPD/Mantoux *placed*	__/__/__	Induration _____mm
PPD/Mantoux *read*	__/__/__	☐ Neg ☐ Pos
Interferon Test	__/__/__	☐ Neg ☐ Pos
Chest x-ray *(if PPD or Interferon positive)*	__/__/__	☐ NI ☐ Abnl ☐ Not Indicated
Vision *(required for new school entrants and children age 4–7 yrs)*	__/__/__ ☐ with glasses	Acuity *Right* ___ / ___ *Left* ___ / ___ Strabismus ☐ No ☐ Yes

IMMUNIZATIONS – DATES CIR Number of Child

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

Influenza	__/__/__	__/__/__	__/__/__	__/__/__
MMR	__/__/__	__/__/__	__/__/__	__/__/__
Varicella	__/__/__	__/__/__		
Td	__/__/__	__/__/__	__/__/__	__/__/__
Tdap __/__/__	Hep A	__/__/__	__/__/__	
Meningococcal	__/__/__	__/__/__		
HPV	__/__/__	__/__/__	__/__/__	
Other, *specify:* _____	__/__/__	_____	__/__/__	

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet

☐ Restrictions *(specify)* _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: __/__/__

Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision

☐ Other _____

ASSESSMENT ☐ **Well Child** (V20.2) ☐ **Diagnoses/Problems** *(list)* **ICD-9 Code**

_____ __ __ __ __

_____ __ __ __ __

_____ __ __ __ __

Health Care Provider Signature | Date __ __ / __ __ / __ __

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

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

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

DOHMH ONLY **PROVIDER I.D.**

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

Comments

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

REVIEWER:

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