With G'd's Name, The Merciful Benefactor, The Merciful Redeemer
Masjid Abdul Muhsi Khalifah
Incorporated

120 Madison Street]
Brooklyn, New York 11216
Tel: 718-783-1279 ● Fax: 718-783-3308

CLARA MUHAMMAD SCHOOL OF MASJID KHALIFAH

REGISTRATION FORM

Child Legal Name: _____ Date of Birth: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone #: _____

Parent/Guardian Information:

Father Legal Name: _____

Preferred Name Used: _____

Employer: _____

Address: _____

Home #: _____ Work #: _____

Mother Legal Name: _____

Preferred Name Used: _____

Employer Name: _____

Address: _____

Home #: _____ Work #: _____

Emergency Contact Name: _____

Address: _____

Telephone #: _____

Relationship to Child: _____

List other siblings:

Name: _____ Age: _____ School Attending: _____

Name: _____ Age: _____ School Attending: _____

Name: _____ Age: _____ School Attending: _____

Name: _____ Age: _____ School Attending: _____

REVISED 09/01

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CLARA MUHAMMAD SCHOOL OF MASJID KHALIFAH

TUITION/ PAYMENT AGREEMENT

Please reserve a place for my child: _____, at the Clara Muhammad School of Masjid Khalifah. As outlined in the payment schedule below, the tuition due is $3,000.00 for the 2001 – 2002 school year

Check one:

/_____/	PLAN A= 1 PAYMENT	
	September 1st.	$3,000
/_____/	PLAN B= 2 PAYMENTS	
	September 1st.	$1,500
	January 1st.	$1,500
/_____/	PLAN C= 3 PAYMENTS	
	September 1st.	$1,000
	December 1st.	$1,000
	March 1st.	$1,000
/_____/	PLAN D =10 PAYMENTS	
	Monthly	$300

Registration fees are non-refundable and are paid separately. All tuition payments are due on the 1st of e very month If payments are received after the 10th of the month, a late fee of $25.00 will be added to your account.

I have read all of the above, and I understand that failure to comply with the terms and condition of this agreement will result in my child being dismissed from the Clara Muhammad School of Masjid Khalifah.

_____ _____
Signature of Parent or Guardian Date

_____
Print

_____ _____
Approved by Date

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CLARA MUHAMMAD SCHOOL OF MASJID KHALIFAH

HEALTH RECORD/EMERGENCY PERMISSION FORM

Child's Name: _____
(Last) (First) (Middle)

Family Name (if different from above): _____

Clinic Card #: _____

Hospital or Medical Insurance Card #: _____

1. Please list (with date) any major illness or injury your child has had in the past month.

_____

2. Please list (with date) any major illness or injury your child has had in the past year.

_____

3. Please list any medical conditions (asthma, health condition, etc.) that your child has.

_____

4. Date of last Tetanus shot (should be within five years) _______________

5. Allergies: _____

_____

6. Does your child have any special dietary restrictions? _____

_____

7. Can your child take part in strenuous activities? _____

8. Please list any *medication your child requires _____

- Please do not send medication to school for teachers to administer. If your child is under treatment for a cold, etc., give first dosage in the morning, at home, and begin dosages once the child returns home from school. Teachers and/or staff will not be permitted to give medication.

-over-

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CLARA MUHAMMAD SCHOOL OF MASJID KHALIFAH

To the Parent or Guardian:

The policy of the school will be to contact the parent or guardian before a student sees a doctor or a hospital. However, in case of emergency, or when neither the parent nor guardian can be reached, the following permission form will allow treatment to be secured.

9. I hereby give permission to Clara Muhammad School of Masjid Khalifah's principal and/or to her adult member of my child's school to transport my child to and from a doctor and/or hospital for emergency treatment.

_____ _____
Parent or Guardian's Signature Date

10. I hereby give my permission to Clara Muhammad School of Masjid Khalifah's principal and/or any other adult member designated to allow hospital personnel and/or a licensed physician to perform emergency treatment and inject or administer drugs in conjunction with such emergency treatment.

_____ _____
Parent or Guardian's Signature Date

11. The following may be given to my child if needed:

Tylenol/Aspirin _____	Cough Syrup _____
External Ointments _____	All of the above _____
Cough Lozenges _____	None of the above _____

12. Additional remarks or information: _____

_____

_____

Parent's or Guardian's Name _____
(Print)

Home Telephone #: _____ Business Telephone #: _____

Emergency Contact's Name: _____ Telephone #: _____

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PHYSICAL EXAMINATION

(To be filled out by Physician – please not information on reverse side)

The purpose of this health record is to provide the staff with pertinent information which will help to serve the needs of this child in day Camps and After school and Youth Center Programs.

IMMUNIZATION HISTORY – This is a record of dates and basic immunization and most recent booster doses.

DPap, DTP or TD	Date _____	Date _____	Date _____	Date _____	Date _____
Polio	Date _____	Date _____	Date _____	Date _____	Date _____
MMR	Date _____	Date _____	Date _____	Date _____	Date _____
Hemophilus Influenza type b					
Hepatitis B	Date _____	Date _____	Date _____	Date _____	Date _____
Varicella	Date _____	Date _____	Date _____	Date _____	Date _____

Other _____

MEDICAL EXAMINATION – To be filled out by licensed physician.

Examination is acceptable when performed no more than 12 months prior to arrival at camp.

Code: S= Satisfactory
X= Not Satisfactory (Explain)
0 = Not Examined

General Appearance _____

Height _____ Weight _____ Blood Pressure _____ Hgb.Test (Date) _____

Urinalysis (Date) _____ Posture and Spine _____ Throat-Tonsils _____

Eyes _____ Vision _____ w/Glasses _____ Extremities _____ Heart _____

Ears _____ Hearing _____ Feet _____ Lungs _____ Skin_____

Nose _____ Teeth _____ Abdomen _____ Hernia _____

Genitalia _____

Neurological Findings, _____

Describe Abnormal Findings and/or Handicapping Conditions._____

_____

Has child ever received products containing horse serum? _____

Allergy: (*Please specify*) _____

Recommendations and restrictions while in camp.

Special Diet _____

Special Medicine (name it) _____

Is parent/guardian sending special medicine? _____

Swimming _____ Diving _____

Activity Restrictions _____

General Appraisal: _____

_____

_____

I have examined the person herein described, reviewed his/her health history and its my opinion that he/she is physically able to engage in Day Camp Round Afterschool and Youth Center activities, except a noted above.

_____M.D.
EXAMINING PHYSICIAN (SIGNATURE)

_____
PHYSICIAN'S NAME (PLEASE PRINT)

Telephone _____ Address _____

Date of Examination _____ _____
ZIP CODE

DCR 7 (Rev. 2/00)

HEALTH RECORD FOR CHILDREN IN DAY CAMPS & AFTERSCHOOL & YOUTH CENTERS
(This side to be filled in by parent before presentation to physician)

NAME OF PROGRAM _____

_____ _____ ____/_____/_____ ___M ❑ _ F ❑___
CHILD'S LAST NAME FIRST NAME BIRTHDATE SEX

Home Address: _____ Phone: _____

Parent or Guardian: _____ Phone: _____

Place of Employment: Father (Guardian) _____ Phone: _____

Mother (Guardian) _____ Phone: _____

In case of emergency, notify: _____ Phone: _____

If Parent, Guardian is not available in an emergency, notify:

1. _____ Phone: _____
2. _____ Phone: _____

Important: Has this camper been exposed to any communicable disease during the three weeks prior to camp attendance:

Yes ❑ No ❑ (if yes, state type of exposure: _____)

HEALTH HISTORY: (Check, giving approximate dates)

	Allergies	**Diseases**
Ear Infections _____	Hay Fever _____	Chicken Pox _____
Rheumatic Fever _____	Ivy Poisoning, etc. _____	Measles _____
Convulsion _____	Insect Stings _____	German Measles _____
Diabetes _____	Penicillin _____	Mumps _____
Behavior _____	Other Drugs _____	Other contagious Illnesses _____
Asthma _____		

Other Past Illnesses _____

Operations or Serious Injuries (Dates) _____

Hospitalization (Dates) _____

Chronic or Recurring Illness _____

Any specific activities to be encouraged? _____

Conditions that require activity to be restricted? _____

Permission for all program activities unless otherwise noted by Dr. _____

Appliance worn (glasses, contacts, etc.)

_____

Medication taken _____

Suggestion from Parent/Guardian _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I do hereby give authority to the Day Camp and Year Round After school and Youth Center Program staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Relationship _____Signature _____ Date _____ Tele. # _____

Department of Health The City of New York Office of Field Operations/Inspections

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CLARA MUHAMMAD SCHOOL OF MASJID KHALIFAH

PARENTAL PERMISSION SLIP

STUDENT'S NAME: _____ CLASS: _____

1. **Physical Education**: I hereby give my child permission to participate in the physical education program at Clara Muhammad School of Masjid Khalifah. I understand that this may include dance. My child is in good physical condition, and he/she may participate without restrictions.

   _____ _____
   Parent or Guardian's Signature Date

2. **Trips**: With the understanding that common-sense measures are exercised to assure the safety of children, I authorize my child to engage in in-school activities. Every precaution will be taken to safeguard the children on excursions, as well as in to her activities, but the school cannot assume responsibility for possible accidents.

   In-School Activities: Also, with the understanding that common sense measures are exercised to assure the safety of children, I authorize my child to engage in in-school activities. Every precaution will be taken to safeguard the children on excursion, as well as in other activities, but the school cannot assume responsibility for possible accidents.

   _____ _____
   Parent or Guardian's Signature Date

Note: Each appropriate section must be signed for your child to participate in physical Education, to go on trips and/or participate in school activities.

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CLARA MUHAMMAD SCHOOL OF MASJID KHALIFAH

SPECIAL DISMISSAL PERMISSION FORM

Name of Student: _____ Grade: _____

Parent's or Guardian's Name: _____

[ ] Yes, my child has permission to leave the school premises on his/her own.

[ ] No, my child does not have permission to leave the school premises on his/her own. Other than myself, my child may be released to the following person(s). I will report any changes in this authorization to the Administrative Office in writing.

1. Name of Alternate _____
   Address _____
   Telephone _(_____)_____ Relationship _____

2. Name of Alternate _____
   Address _____
   Telephone _(_____)_____ Relationship _____

3. Name of Alternate _____
   Address _____
   Telephone _(_____)_____ Relationship _____

BUS SERVICE

Name of Bus Driver _____

Address _____ Phone: _____

Name of Alternate Drive (if any) _____ Phone: _____

Parent's or Guardian's Signature: _____ Date: _____

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PARENTAL VOLUNTEER SURVEY

Dear Parents,

We are planning many exciting programs and activities for your child this year. To ensure success and enjoyment for all, we are going to need your help. Just a little bit of your time can make a big difference! Please complete this questionnaire.

Parent's Name: _____ Telephone _____ Date _____

I work: at home days evenings Best time to call is _____

I am interested in volunteering in the classroom. I'd like to:	I am interested in helping in other areas of the school. I'd like to:	I am interested in helping by working at home: I'd like to:
• Work with individual students. • Work will small groups of students • Read to students. • Listen to students read. • Help with teacher's clerical work. • Prepare materials. • Attend field t rips. • Help students with dramatic performances. • Help out in class with art projects. • Appear as a guest speaker to: Share my professional experience. Share my travels. Share my culture. Share a talent, skill or craft. • Other: _____.	• Organize and/or participate in activities that occur during school hours. • Organize and/or participate in activities that do not **occur** during school hours. Recruit parents, citizens and local businesses to participate in special program. • Type or do clerical work. • Prepare newletters. • Prepare posters, displays etc. • Do photocopying and laminating. • Work in library. • Photography school activities. • Provide transportation for special event. • Other: _____.	• Donate eatable items. • Correct papers. • Sew. • Cut out letters. • Prepare bulletin boards. • Enter information on computer. • Read students' creative writing stories. • Gather resource materials. • Other: _____. .

Please tell us about your special talents and skills, or about helpful community resources you can direct us to. We are always in need of printing services and in locating funds or donations for programs, supplies and equipment.

_____

_____

_____

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