SOUTHFIELD INSTITUTE

The highest standard of academics, spirit, and humanism

375 Sand Lane, Staten Island, NY, 10305 · 718-390-0070 · Fax: 718-390-0201
E-mail: administration@southfieldinstitute.com

Application for Admission for the year of 2025 – 2026

Application Fee & Security Deposit paid on _____ For Grade _____

Student's Name: _____
First Middle Last

Date of Birth: _____ Male_____ Female _____

Student's Home Address: _____

_____

*****

Emergency Phone #: _____ **Emergency Contact Name:** _____

Parent/Guardian # 1

_____
First Name **Last Name**

Home Phone: _____ Cell: _____ Office: _____

E-mail Address: _____

Parent/Guardian # 2

_____
First Name **Last Name**

Home Phone: _____ Cell: _____ Office: _____

E-mail Address: _____

*****

(over)

Emergency Contacts other than Parents:

Name: _____ Phone: _____

Relationship to the Student _____

Name: _____ Phone: _____

Relationship to the Student _____

Student's Allergies: _____

☐ I acknowledge that I have received and agree with School Disciplinary Policy and Rules.

Signature of Parent/Guardian: _____

*****

I **give** authority to *Southfield Institute / Smiles Around Us Academy* staff to obtain emergency medical treatment for my child, with the understanding that the family will be notified as soon as possible.

Signature: _____ Print Name: _____

Relationship to the Student: _____ Date: _____

*****

Please choose one choice and sign below:

I give__ /do not give__ permission to my child to go on local walking trips outside the school building.

I give__ /do not give__ permission for my child's picture to be posted on the school website & social media.

Signature: _____ Date: _____ Relationship to the Student: _____

*****

Afterschool Hours:

I, _____, would like to register my child,

_____, for the extended afterschool hours of 4:00pm-6:00pm.

I agree to pay the monthly $250 tuition for afterschool extended care.

Parent's signature _____ **Date:** _____

NYC Department of Education

EMERGENCY CONTACT CARD

SCHOOL YEAR 20__ - 20 __

STUDENT INFORMATION

Student Last Name | Student First Name | M.I.

Date of Birth (mm/dd/yyyy) | Gender | OSIS ID #

Parent/Guardian Last Name (Student resides with) | Parent/Guardian First Name | Relationship

Parent's Preferred Language of Communication (Written) | Parent's Preferred Language of Communication (Oral)

Home Telephone | Work Telephone | Cell Phone

Email

Address (House Number) | Apartment #

City | State: N Y | Zip Code | Borough

Other Parent/Guardian Last Name | Other Parent/Guardian First Name | Other Relationship

Other Parent/Guardian's Preferred Language of Communication (Written) | Other Parent/Guardian's Preferred Language of Communication (Oral)

Other Home Telephone | Other Work Telephone | Other Cell Phone

Other Email

Other Address (House Number) | Other Apartment #

Other City | State: N Y | Other Zip Code | Other Borough

EMERGENCY CONTACTS

List below names of three (3) persons who may be called in case of emergency or if child is sick in school.
CHILD WILL BE RELEASED ONLY TO PERSONS NAMED ON THIS CARD.

Name	Telephone	Relationship

NO ACCESS

If there is a person who may NOT HAVE ACCESS to child, please indicate:

Name	Relationship	Order of Protection Exists?
		■ Yes ☐ No

IMPORTANT- PLEASE COMPLETE NEXT PAGE >>

Updated: 07/16/20

HEALTH INFORMATION

Name of Physician/Clinic: _____ Telephone _____

Health Alert

Does child have any health condition that may affect participation in physical activities? ☒ Yes ☐ No

Limitations _____ (e.g., stair climbing, participation in gym)

Allergies _____

504 services for the current year? ☒ Yes ☐ No Previous Years? ☒ Yes ☐ No

My child has (X any that apply): ☐ Private health insurance ☐ Medicaid ☐ No health insurance

If "No Health Insurance," are you willing to share contact information from this card to learn about insurance options? ☒ Yes ☐ No

If none of the named contacts can be reached, what do you wish the school to do if your child is sick or injured?

_____

It is understood that in the final disposition of an emergency case, the judgment of the school authorities will prevail. The recommendation of the parent as indicated above will be respected as far as possible.

SIBLINGS

Sibling's Last Name	Sibling's First Name	Sibling's School of Attendance

SIGNATURE OF PARENT/GUARDIAN

Principal will be notified in writing of any changes to information on this card _____

Signature of Parent/Guardian

FOR SCHOOL USE ONLY

To be completed by school staff only.

Grade _____ Class _____ Room No. _____ Teacher _____

List below contacts made for emergency, illness or injury. Relevant records from Health Record _____

Date	Contact	Reason	Disposition

NYC Health

Authorized Escorts List Form

The New York City Health Code requires child care centers to obtain and maintain, for every child, a list of all persons authorized by the parent/ guardian to escort the child from child care. The child care center shall not release any child to any individual who has not been identified by the parent/ guardian as a person who is authorized to escort a child out of the center.

Instructions: *The parent/ guardian must complete, sign, and return this form to the child care center upon enrollment and update this form immediately when there is any change in authorized escort information.*

I, _____, authorize this child care center to release my child,
(parent/ guardian name)

_____, to the individuals I have identified below.
(child name)

Name:			
Relationship to child:			
Home address:			
Preferred contact:	☐ Mobile/Cell Telephone ☐ Text (Mobile)	☐ Home Telephone ☐ E-mail	☐ Work Telephone
Telephone:	*Mobile/Cell:*		
	Home:	*Work:*	
E-mail:			

Name:			
Relationship to child:			
Home address:			
Preferred contact:	☐ Mobile/Cell Telephone ☐ Text (Mobile)	☐ Home Telephone ☐ E-mail	☐ Work Telephone
Telephone:	*Mobile/Cell:*		
	Home:	*Work:*	
E-mail:			

Parent/ Guardian Signature: _____

Date: _____

In accordance with the requirements of the New York City Health Code, Article 47, Section 47.57(h)(1) child care centers must obtain and maintain for every child a list of the name, relationship to child, address and contact information of every person the parent has authorized to escort a child from the child care service. The permittee shall not release any child to any individual who has not been identified by the parent(s)/guardian(s) as a person who is authorized to escort a child out of the service.

Allergy Response Plan

Student's Name: _

DOB: _____

Teacher/Class: _____ School: _____

ALLERGY TO: _____

High risk for severe reaction (e.g. hx asthma): _____Yes _____No

Attach Photo Here

General Signs of Severe Allergic Reaction:

Systems:	Symptoms:
Mouth:	Itching and swelling of lips, tongue or mouth
Throat*:	Itching and/or a sense of tightness in throat, hoarseness, and hacking cough Skin: hives, itchy rash, and/or swelling of face or extremities
Gut:	Nausea, abdominal cramps, vomiting and/or diarrhea
Lung*:	Shortness of breath, repetitive coughing and/or wheezing
Heart*:	"Thready pulse", "passing out"

Note: the severity of symptoms can change quickly.

*These symptoms can potentially progress to a life-threatening situation.

If Exposure to Allergen is Suspected and/or Symptoms are:

1. Give (medicine/dose/route)_____ IMMEDIATELY!
2. Then call 911/EMS (ask for advanced life support) following school procedures for 911.
3. Call parent/guardian _____or emergency contacts.
4. Call Dr. _____ at _____

DO NOT HESITATE TO CALL 911!

Trained School Staff

1. _____ Title _____ Room _____
2. _____ Title _____ Room _____
3. _____ Title _____ Room _____

Emergency Contacts (other than Parent/Guardian)

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

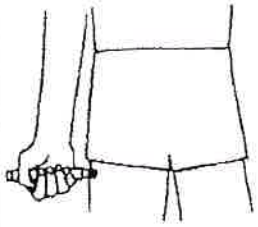
Nurse's signature: _____ Date: _____

Parent/Guardian signature: _____ Date: _____

EPIPEN® AND EPIPEN® JR. DIRECTIONS

1. **Pull off gray activation cap.**

2. **Hold black tip near outer thigh (always apply to thigh).**



3. **Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. The EpiPen® unit should then be removed and taken with you to the Emergency Room. Massage the injection area for 10 seconds.**

(Adapted from the Food Allergy and Anaphylaxis Network)

HEALTH INFORMATION

Name of Physician/Clinic: _____ Telephone ( ) _____

Health Alert

Does child have any health condition that may affect participation in physical activities? Yes_____ No _____

Limitations _____ (e.g., stair climbing, participation in gym)

Allergies _____

504 services for the current year? Yes _____ No _____ Previous Year? Yes _____ No _____

My child has (X any that apply): Private health insurance _____; Medicaid _____; No health insurance _____

If "No Health Insurance", are you willing to share contact information from this card to learn about insurance options? Yes _____ No_____

If none of the named contacts can be reached, what do you wish the school to do if your child is sick or injured?

_____

It is understood that in the final disposition of an emergency case, the judgment of the school authorities will prevail. The recommendation of the parent as indicated above will be respected as far as possible.

Siblings: Last Name	First Name	School of Attendance

FOR SCHOOL USE

List below contacts made for emergency, illness or injury. Relevant records from Health Record _____

Date	Contact	Reason	Disposition
/ /			
/ /			
/ /			

EMERGENCY CONTACT CARD (Print information) SCHOOL YEAR 200___ to 200___

Student: Last Name_____ First _____ MI ___ DOB _____ Sex ___ ID# _____
Parent/Guardian (Student resides with): _____ Relationship _____
Parent's Preferred Language of Communication: Written _____ Oral _____
Home Telephone ( )_____ Work Telephone ( )_____ Cell No. ( )_____ E-mail _____
Address _____ Apt. ___ Borough _____ ZIP _____
Other Parent/Guardian: _____ Relationship _____
Parent's Preferred Language of Communication: Written _____ Oral _____
Home Telephone ( )_____ Work Telephone ( )_____ Cell No. ( )_____ E-mail _____
Address _____ Apt. ___ Borough _____ ZIP _____

List below names of three (3) persons who may be called in case of emergency or if child is sick in school.
CHILD WILL BE RELEASED ONLY TO PERSONS NAMED ON THIS CARD.
Name _____ Telephone ( )_____ Relationship _____
Name _____ Telephone ( )_____ Relationship _____
Name _____ Telephone ( )_____ Relationship _____

If there is a person who may NOT HAVE ACCESS to child, please indicate:
Name _____ Relationship _____ Order of Protection Exists? Yes ___ No ___

Principal will be notified in writing of any changes to information on this card _____
Signature of Parent/Guardian

IMPORTANT- PLEASE COMPLETE REVERSE SIDE OF THIS CARD >

Grade _____ Class _____ Room No. _____ Teacher _____