COOKING

ARTS CRAFTS

MUSIC

CULTURE

MOVEMENT

FITNESS

FRIENDS

KULANU

**WHAT:** A fun-filled three hour inclusion program for children with special needs focused on interaction and friendship through recreation. Participants are paired with shadows and peers. Together, functional and fun activities take place.

***Activities include adaptive art, movement, music, fitness, cooking, cultural activities, and more!***

**WHEN:** Sundays (October-May) from 9:00am -12:00pm

**WHERE:** Kulanu Center for Special Services
620 Central Avenue, Cedarhurst, NY 11516

**WHO:** Children ages 5-21

**For more information please contact:**

**Amy Eisenberg at 516-569-3083 x138 or amy@kulanukids.org**
**Nicole Callan-Grima:nicole@kulanukids.org**

www.kulanukids.org

## Program Registration Form 2015-2016

Child's Name (First & Last): ______________________ Date of Birth: __________

Street Address: ____________________ City: __________ Zip: __________

Gender: (CIRCLE) M F Home Phone number: ( ) ____________________

Mother's Name: ______________ Cell: ______________ Email: ______________

Father's Name: ______________ Cell: ______________ Email: ______________

Emergency Contact Person: ____________________ Cell: ______________

Relationship to applicant: ________________________________________

Current School: ____________________________ Grade: __________

How did you hear about Sunday Club? ______________________________

*If you have more than one child to enroll, please make and complete additional copies of this form for each child.*

# Sunday Club

**@ Kulanu Center for Special Services**
**620 Central Avenue**
**Cedarhurst, NY 11516**
**Sundays 9:00am-12:00 noon**
**October 18,2015 - May 15, 2016**

## REQUIRED FEES

**FAMILY MEMBERSHIP FEE: $300**
***(Entitles you to Free Kulanu Fair admission bracelet & discounted Vacation Respite rates)***

**PLUS MONTHLY ACTIVITY FEE: $95**
***(Must be paid prior to 1st of each month. Or you can pre-pay $600 one-time yearly rate)***

**ABSOLUTELY NO REFUNDS OR DISCOUNTS DUE TO ABSENCES, ILLNESS OR WITHDRAWALS**

# Social Services Payment Form

**Checks payable to: Kulanu**
**Mail to: Kulanu, PO Box 305, Cedarhurst, NY 11516**

☐ **Check here if you want to pre-pay the monthly activities fee at $600 (one-time yearly rate)**

**OR**

**Please charge my credit card as indicated below on the first of each month**

**Credit Card (3% surcharge) check box: ☐American Express Card ☐MasterCard ☐VISA ☐Discover**

Card Number____________________________ Exp. Date__________ Security Code ________

Name (as it appears on card) ______________________Signature__________________________

**Many businesses offer their employees a Matching Gift Program. This creates an easy way for the donor to increase the size of the gift- by having the company the donor works for- match the gift they provide.**

☐ **Check here** if your employer offers a Matching Gift Program

Name of Employer: ____________________________

Address: ____________________________

____________________________

Phone Number: ________________________

**ABSOLUTELY NO REFUNDS OR DISCOUNTS DUE TO ABSENCES, ILLNESS OR WITHDRAWALS**

**Kulanu evaluates children's appropriateness for programs on an ongoing basis and reserves the right to terminate any student enrollment during the course of a program.**

PLEASE ATTACH A RECENT PHOTO OF YOUR CHILD

# *Applicant Information Form 2015-2016*

**New members** please fill out entire packet
**Returning members** please update information

**Personal Information:**

Child's Name (first & last): ______________________________

Date of Birth: __________ Gender: ________ Age: ________

Address: ______________________________
______________________________

Home Phone Number: ( ) ______________

Mother's Name: ______________________________ Cell: ( ) ______________

Father's Name: ______________________________ Cell: ( ) ______________

Preferred E-Mail Address: ______________________________

If divorced, please indicate custody arrangement:
______________________________
______________________________

Emergency Contact Person: ______________________________

Phone: ______________________________ Relationship to Child: ______________

**Medical Information:**

Physician's Name: ______________________________ Phone: ______________

Disability/Disabilities (please list diagnosis/diagnoses): ______________________________
______________________________

**Medication(s) currently taking:**

| Medication Name | Reason for taking | Dosage | Specific times taken each day |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Allergies:**

___yes _____ no If yes, please specify: ______________________________
Peanut/Nut Allergy: ____ yes ____no
Does your child use an Epi-Pen? ____ yes ____ no
Please describe reaction and intervention to allergies: ______________________________
______________________________

Dietary Restrictions: ____ yes ____ no if yes, please specify: ______________________________
______________________________

Does your child need mobility assistance: ___ yes ___ no
If yes, please explain: ___
Does he/she use a wheelchair? ___ yes ___ no
Does he/she wear an orthopedic brace(s)? ___ yes ___ no
Does your child have a seizure disorder? ___ yes ___ no
If yes, how frequently does she/he have seizures? ___
Date of last seizure: ___
Does your child wear a protective helmet? ___ yes ___ no
Does your child wear glasses, contacts, protective eye wear? ___ yes ___ no

**Toileting Concerns:**

Does your child indicate when he/she needs to use the restroom? ___ yes ___ no
If no, please explain: ___
Does your child need assistance in the bathroom? ___ yes ___ no
If yes, please explain: ___
Does your child require diapers? ___ yes ___ no

**Behavior/Personality/Communication:**

Describe your child on his/her best day:
___
___

Describe the best way to get your child involved in an activity:
___
___

Does your child display aggressive behavior? ___ yes ___ no
If yes, please explain: ___
___
What triggers this behavior(s)? ___

Is there a Behavior Intervention Plan (BIP) implemented at school? ___ yes ___ no
*******If yes, please attach the Behavior Intervention Plan (BIP) to this application*******

Does your child have a history of eloping? Walking away from events? ___ yes ___ no
If yes, when does this occur and how can this be prevented? ___
___

Does your child have any phobias/fears? (i.e., fear of large crowds, fear of heights, etc.)? ___ yes ___ no
If yes, please explain: ___

Are there any settings or activities that may cause behavior difficulties (i.e., loud sounds, flashing lights, etc.)?
___ yes ___ no
If yes, please explain: ___
___

Please describe the best way to introduce or explain a new task or transitions:
___
___

Please indicate what types of things/tasks would possibly frustrate or anger your child:
___
___

Please indicate the best way to redirect or engage your child's attention:

______________________________________________

______________________________________________

Please circle which form(s) of communication your child uses:

Sounds Gestures Verbal Language Sign Language Communication Board

Communication Device (provided) Other: ____________

**Interests/Activities:**

List at least three activities your child enjoys participating in:
1)______________________ 2) ______________________
3) ______________________ ______________________

Please list activities your child does NOT enjoy:

______________________________________________

List reinforcements that your child is willing to work for( i.e. verbal, food (what type), check list, etc.)

______________________________________________

______________________________________________

______________________________________________

**Required Documents**

**Please submit the following documents along with this completed application to:**

**Kulanu , 620 Central Avenue, Cedarhurst, NY 11516 (Attn: Amy Eisenberg)**

- ☐ Copy of your child's Current Individualized Education Plan (IEP)
- ☐ Current physical examination from doctor (signed and dated)
- ☐ Copy of your child's Social-Emotional report (usually completed by school district every three years)
- ☐ Psychological Evaluation (within 3 years)
- ☐ Behavior Intervention Plan (BIP), if applicable
- ☐ OPWDD Letter of Eligibility, if applicable

## Consents:

I hereby give consent to Kulanu to:

- ☐ Obtain emergency medical care or treatment, to be used only if I cannot be reached immediately. _____ yes _____ no
- ☐ Take photographs of my child to be used for publicity, social media, educational purposes or professional training. _____ yes _____ no
- ☐ Videotape my child during the program for publicity, social media, educational purposes or professional training. _____ yes _____ no

**Signature of Parent/Guardian: _______________________________________________ Date: _________**

# 2015-2016 CALENDAR

**TIME: 9:00 AM-12:00 PM**
**DROP OFF/PICK UP LOCATION: KULANU CENTER FOR SPECIAL SERVICES**
**620 CENTRAL AVE., CEDARHURST, NY 11516**
**516-569-3083**

| | |
|---|---|
| **SEPTEMBER 2015**<br><br>**9/27: Staff & Volunteer Orientation** | **FEBRUARY 2016**<br><br>2/7, 2/21, 2/28<br><br>**2/14 (NO PROGRAM) PRESIDENTS' DAY** |
| **OCTOBER 2015**<br><br>**10/18 FIRST DAY OF PROGRAM**<br>10/25 | **MARCH 2016**<br><br>3/6, 3/13, 3/20, 3/27 |
| **NOVEMBER 2015**<br><br>11/1, 11/8, 11/15, 11/22<br><br>**11/29 (NO PROGRAM) THANKSGIVING** | **APRIL 2016**<br><br>4/3, 4/10, 4/17<br><br>**4/24 (NO PROGRAM) SPRING BREAK** |
| **DECEMBER 2015**<br><br>12/6, 12/13, 12/20, 12/27 | **MAY 2015**<br><br>5/1, 5/8<br><br>**5/15 LAST DAY OF PROGRAM** |
| **JANUARY 2016**<br><br>1/3, 1/10, 1/31<br><br>**1/17 and 1/24 (NO PROGRAM)WINTER RECESS** | |

**CANCELLATIONS**

If the program is cancelled due to a snowstorm or other weather related event, there will be a recorded message at 516-569-3083.

**www.kulanukids.org**