

### Dear BEES Families,

Welcome to the 2026-2027 school year at Brooklyn Environmental Exploration School. At BEES, our vision is simple: students are learning, happy, and safe. This year's theme, Better Because of Us, reminds us that every student, family and staff member makes our community stronger.

Please complete every page marked RETURN TO MAIN OFFICE or RETURN TO SCHOOL NURSE and send the stapled packet back with your child as soon as possible. Keep the pages marked KEEP AT HOME. Complete one packet for each student. Contact the Main Office if you need help or translated materials.

We look forward to a joyful, safe and successful year together.

Sincerely,

**Craig Garber, Principal**

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### Estimadas familias de BEES:

Les damos la bienvenida al año escolar 2026-2027 en Brooklyn Environmental Exploration School. En BEES, nuestra visión es sencilla: los estudiantes aprenden, son felices y están seguros. El lema de este año, Better Because of Us (Mejores gracias a nosotros), nos recuerda que cada estudiante, familia y miembro del personal fortalece nuestra comunidad.

Complete todas las páginas marcadas DEVUELVA A LA OFICINA PRINCIPAL o DEVUELVA A LA ENFERMERÍA ESCOLAR y envíe el paquete grapado con su hijo lo antes posible. Conserve las páginas marcadas PARA CONSERVAR EN CASA. Complete un paquete por cada estudiante. Comuníquese con la Oficina Principal si necesita ayuda.

Atentamente,

**Craig Garber, Director**

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*Reverse side of: Principal's Family Letter*



SCHOOL YEAR 20\_\_ - 20\_\_

**You can update your contact information online using your NYC Schools Account at [schoolsaccount.nyc.gov](https://schoolsaccount.nyc.gov). Don't have an account? Check out [schools.nyc.gov/nycsa](https://schools.nyc.gov/nycsa).**

## STUDENT INFORMATION

|                            |  |           |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |      |  |
|----------------------------|--|-----------|--|--|--|--|--|--|--|--------------------|--|--|--|--|--|--|--|--|--|------|--|
| Student Last Name          |  |           |  |  |  |  |  |  |  | Student First Name |  |  |  |  |  |  |  |  |  | M.I. |  |
| Date of Birth (mm/dd/yyyy) |  | OSIS ID # |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |      |  |

**If you have filled out the information in NYCSA:**

- ☐ Emergency contact information is correct in NYCSA. No need to update form.
- ☐ Updated emergency contact information is below.

**This Guardian Can :** ☐ Be Contacted in Emergencies ☐ Pick Up Student ☐ Receive School Mailings (check all that apply).

|                                                        |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |       |  |  |  |  |                                                     |  |  |  |  |  |  |  |  |  |         |  |  |  |  |                           |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--------------------------------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|-------|--|--|--|--|-----------------------------------------------------|--|--|--|--|--|--|--|--|--|---------|--|--|--|--|---------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 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                                          |  |  |  |  |  |  |  |  |  |         |  |  |  |  | <div>Y</div> <div>N</div> |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| OK to Text                                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |       |  |  |  |  |                                                     |  |  |  |  |  |  |  |  |  |         |  |  |  |  |                           |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Email                                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |       |  |  |  |  |                                                     |  |  |  |  |  |  |  |  |  |         |  |  |  |  |                           |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Address (House Number)                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |       |  |  |  |  |                                                     |  |  |  |  |  |  |  |  |  |         |  |  |  |  | Apartment #               |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| City                                                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  | State |  |  |  |  | Zip Code                                            |  |  |  |  |  |  |  |  |  | Borough |  |  |  |  |                           |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**This Guardian Can:** ☐ Be Contacted in Emergencies ☐ Pick Up Student ☐ Receive School Mailings (check all that apply).

|                                                                           |  |  |  |  |  |  |  |  |  |                                      |  |          |  |  |  |  |         |  |  |                                                                        |  |  |  |  |  |  |  |             |  |   |  |   |  |  |  |  |  |  |  |
|---------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|--------------------------------------|--|----------|--|--|--|--|---------|--|--|------------------------------------------------------------------------|--|--|--|--|--|--|--|-------------|--|---|--|---|--|--|--|--|--|--|--|
| Secondary Parent/Guardian Last Name                                       |  |  |  |  |  |  |  |  |  | Secondary Parent/Guardian First Name |  |          |  |  |  |  |         |  |  | Relationship                                                           |  |  |  |  |  |  |  |             |  |   |  |   |  |  |  |  |  |  |  |
| Secondary Parent/Guardian's Preferred Language of Communication (Written) |  |  |  |  |  |  |  |  |  |                                      |  |          |  |  |  |  |         |  |  | Secondary Parent/Guardian's Preferred Language of Communication (Oral) |  |  |  |  |  |  |  |             |  |   |  |   |  |  |  |  |  |  |  |
| Secondary Home Telephone                                                  |  |  |  |  |  |  |  |  |  | Secondary Work Telephone             |  |          |  |  |  |  |         |  |  | Secondary Cell Phone                                                   |  |  |  |  |  |  |  |             |  | Y |  | N |  |  |  |  |  |  |  |
| Secondary Email                                                           |  |  |  |  |  |  |  |  |  |                                      |  |          |  |  |  |  |         |  |  | OK to Text                                                             |  |  |  |  |  |  |  |             |  |   |  |   |  |  |  |  |  |  |  |
| Secondary Address (House Number)                                          |  |  |  |  |  |  |  |  |  |                                      |  |          |  |  |  |  |         |  |  |                                                                        |  |  |  |  |  |  |  | Apartment # |  |   |  |   |  |  |  |  |  |  |  |
| City                                                                      |  |  |  |  |  |  |  |  |  | State                                |  | Zip Code |  |  |  |  | Borough |  |  |                                                                        |  |  |  |  |  |  |  |             |  |   |  |   |  |  |  |  |  |  |  |

## EMERGENCY CONTACTS

List below names of three additional people who may be called in case of emergency or if child is sick in school.

**CHILD WILL BE RELEASED ONLY TO PEOPLE NAMED ON THIS CARD.**

| Name | E-mail | Telephone | Relationship |
|------|--------|-----------|--------------|
|      |        |           |              |
|      |        |           |              |
|      |        |           |              |

[illegible]

Updated: August 2021

## NO ACCESS

If there is a person who may **NOT HAVE ACCESS** to child, please indicate:  
Please submit a copy of the order of protection to your child's school.

| Name | Relationship | Order of Protection Exists?                              | Effective Date of Court Order |
|------|--------------|----------------------------------------------------------|-------------------------------|
|      |              | <input type="checkbox"/> Yes <input type="checkbox"/> No |                               |

## HEALTH INFORMATION

Name of Physician/Clinic: \_\_\_\_\_ Telephone \_\_\_\_\_

- ☐ Allergist/Immunologist ☐ Cardiologist ☐ Dermatologist ☐ Development/Behavioral Specialist  
☐ Neurologist ☐ Pulmonologist ☐ Other \_\_\_\_\_

### 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)

### Known Diagnoses (please check all that apply)

- ☐ Asthma ☐ Seizures ☐ Allergies/Anaphylaxis ☐ Diabetes ☐ None ☐ Other \_\_\_\_\_

### Allergies (select all that apply)

- ☐ Milk ☐ Eggs ☐ Peanuts ☐ Tree Nuts (Other Nuts) ☐ Fish  
☐ Shellfish ☐ Soy ☐ Wheat ☐ Other \_\_\_\_\_

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

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

- ☐ By checking this box, I agree to be contacted by elected School, District, and/or City-wide parent leader volunteers regarding events, updates, and other matters connected to my school community.
- ☐ By checking this box, I agree that my contact information can be shared with elected School, District, and/or City-wide parent leader volunteers so I can be updated on events and other matters connected to my school community.

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

## FOR OFFICE 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 |
|------|---------|--------|-------------|
|      |         |        |             |
|      |         |        |             |
|      |         |        |             |

Complete one form for each student. This supplements the NYCPS Emergency Contact Form.

Student name \_\_\_\_\_ Class \_\_\_\_\_

Preferred name (if different) \_\_\_\_\_ Home language \_\_\_\_\_

### REGULAR DISMISSAL PLAN

- ☐ My child may leave school independently at regular dismissal.
- ☐ My child must be picked up by an authorized adult listed on the Emergency Contact Form.
- ☐ My child follows another regular dismissal plan described below.

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### Sibling dismissal information (name, class and plan)

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### Important information BEES should know immediately

Include health, mobility, custody or safety information. Submit medical orders directly to the school nurse.

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### Best way to reach our family

- ☐ Phone call ☐ Text message ☐ Email ☐ TalkingPoints

Parent/guardian name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Phone \_\_\_\_\_

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*Reverse side of: Family Information & Dismissal Plan*



Department of Health  
and Mental Hygiene

Department  
of Education

CHILD & ADOLESCENT  
HEALTH EXAMINATION FORM

Please  
Print Clearly

NYC ID (OSIS)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

|                                                                                                    |  |                                                                                              |          |                                                                              |                                                                                                                                                                                                                                                                     |                                                                      |                                                         |  |
|----------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|----------|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|---------------------------------------------------------|--|
| Child's Last Name                                                                                  |  | First Name                                                                                   |          | Middle Name                                                                  |                                                                                                                                                                                                                                                                     | Sex <input type="checkbox"/> Female<br><input type="checkbox"/> Male | Date of Birth (Month/Day/Year)<br>____/____/____        |  |
| Child's Address                                                                                    |  |                                                                                              |          | Hispanic/Latino?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Race (Check ALL that apply) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White<br><input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other _____ |                                                                      |                                                         |  |
| City/Borough                                                                                       |  | State                                                                                        | Zip Code | School/Center/Camp Name                                                      |                                                                                                                                                                                                                                                                     | District<br>Number ____                                              | Phone Numbers<br>Home _____<br>Cell _____<br>Work _____ |  |
| Health insurance <input type="checkbox"/> Yes<br>(including Medicaid)? <input type="checkbox"/> No |  | <input type="checkbox"/> Parent/Guardian Last Name<br><input type="checkbox"/> Foster Parent |          | First Name                                                                   |                                                                                                                                                                                                                                                                     | Email                                                                |                                                         |  |

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

|                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                               |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Birth history (age 0-6 yrs)<br><input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation<br><input type="checkbox"/> Complicated by _____ |  | Does the child/adolescent have a past or present medical history of the following?<br><input type="checkbox"/> Asthma (check severity and attach MAF):<br>If persistent, check all current medication(s):<br>Asthma Control Status<br><input type="checkbox"/> Anaphylaxis<br><input type="checkbox"/> Behavioral/mental health disorder<br><input type="checkbox"/> Congenital or acquired heart disorder<br><input type="checkbox"/> Developmental/learning problem<br><input type="checkbox"/> Diabetes (attach MAF)<br><input type="checkbox"/> Orthopedic injury/disability<br><b>Explain all checked items above.</b> |  | <input type="checkbox"/> Intermittent<br><input type="checkbox"/> Quick Relief Medication<br><input type="checkbox"/> Well-controlled<br><input type="checkbox"/> Seizure disorder<br><input type="checkbox"/> Speech, hearing, or visual impairment<br><input type="checkbox"/> Tuberculosis (latent infection or disease)<br><input type="checkbox"/> Hospitalization<br><input type="checkbox"/> Surgery<br><input type="checkbox"/> Other (specify) _____<br><b>Addendum attached.</b> |  | <input type="checkbox"/> Mild Persistent<br><input type="checkbox"/> Inhaled Corticosteroid<br><input type="checkbox"/> Poorly Controlled or Not Controlled<br><input type="checkbox"/> Moderate Persistent<br><input type="checkbox"/> Oral Steroid<br><input type="checkbox"/> Other Controller <input type="checkbox"/> None |  | Medications (attach MAF if in-school medication needed)<br><input type="checkbox"/> None <input type="checkbox"/> Yes (list below)<br>_____<br>_____<br>_____ |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|

Attach MAF if in-school medications needed

|                                                      |  |                                                                   |                                           |                                                 |                                             |                                          |
|------------------------------------------------------|--|-------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------|---------------------------------------------|------------------------------------------|
| PHYSICAL EXAM Date of Exam: ____/____/____           |  | General Appearance:<br><input type="checkbox"/> Physical Exam WNL |                                           |                                                 |                                             |                                          |
| Height _____ cm (____ %ile)                          |  | Ni Abnl<br><input type="checkbox"/> Psychosocial Development      | Ni Abnl<br><input type="checkbox"/> HEENT | Ni Abnl<br><input type="checkbox"/> Lymph nodes | Ni Abnl<br><input type="checkbox"/> Abdomen | Ni Abnl<br><input type="checkbox"/> Skin |
| Weight _____ kg (____ %ile)                          |  | <input type="checkbox"/> Language                                 | <input type="checkbox"/> Dental           | <input type="checkbox"/> Lungs                  | <input type="checkbox"/> Genitourinary      | <input type="checkbox"/> Neurological    |
| BMI _____ kg/m <sup>2</sup> (____ %ile)              |  | <input type="checkbox"/> Behavioral                               | <input type="checkbox"/> Neck             | <input type="checkbox"/> Cardiovascular         | <input type="checkbox"/> Extremities        | <input type="checkbox"/> Back/spine      |
| Head Circumference (age ≤2 yrs) _____ cm (____ %ile) |  | Describe abnormalities:                                           |                                           |                                                 |                                             |                                          |
| Blood Pressure (age ≥3 yrs) _____ / _____            |  |                                                                   |                                           |                                                 |                                             |                                          |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                                                                                                                |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| DEVELOPMENTAL (age 0-6 yrs)<br>Validated Screening Tool Used? _____ Date Screened ____/____/____<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>Screening Results: <input type="checkbox"/> WNL<br><input type="checkbox"/> Delay or Concern Suspected/Confirmed (specify area(s) below):<br><input type="checkbox"/> Cognitive/Problem Solving <input type="checkbox"/> Adaptive/Self-Help<br><input type="checkbox"/> Communication/Language <input type="checkbox"/> Gross Motor/Fine Motor<br><input type="checkbox"/> Social-Emotional or Personal-Social <input type="checkbox"/> Other Area of Concern: _____ |  | Nutrition<br>< 1 year <input type="checkbox"/> Breastfed <input type="checkbox"/> Formula <input type="checkbox"/> Both<br>≥ 1 year <input type="checkbox"/> Well-balanced <input type="checkbox"/> Needs guidance <input type="checkbox"/> Counseled <input type="checkbox"/> Referred<br>Dietary Restrictions <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) |  | Hearing Date Done Results<br>< 4 years: gross hearing ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred<br>OAE ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred<br>≥ 4 yrs: pure tone audiometry ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred |  |
| Describe Suspected Delay or Concern:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | SCREENING TESTS Date Done Results<br>Blood Lead Level (BLL) ____/____/____ _____ µg/dL<br>(required at age 1 yr and 2 yrs and for those at risk)                                                                                                                                                                                                                                        |  | Vision Date Done Results<br><3 years: Vision appears: ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl<br>Acuity (required for new entrants and children age 3-7 years) ____/____/____ Right ____/____/____<br>Left ____/____/____<br><input type="checkbox"/> Unable to test                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | Lead Risk Assessment<br>(at each well child exam, age 6 mo-6 yrs) ____/____/____ <input type="checkbox"/> At risk (do BLL)<br><input type="checkbox"/> Not at risk                                                                                                                                                                                                                      |  | Screened with Glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Strabismus? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | Child Care Only                                                                                                                                                                                                                                                                                                                                                                         |  | Dental<br>Visible Tooth Decay <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Urgent need for dental referral (pain, swelling, infection) <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Dental Visit within the past 12 months <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                              |  |
| Child Receives EI/CPSE/CSE services <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | Hemoglobin or Hematocrit ____/____/____ _____ g/dL _____ %                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                |  |

|                                                                               |  |                                                                          |  |                           |                |
|-------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|--|---------------------------|----------------|
| CIR Number                                                                    |  | Provider Confirmed History of Varicella Disease <input type="checkbox"/> |  | Please attach lab reports |                |
| IMMUNIZATIONS – DATES                                                         |  |                                                                          |  | Positive IgG              | Date           |
| DTP/DtAP ____/____/____ Td ____/____/____                                     |  |                                                                          |  | Hepatitis B               | ____/____/____ |
| Tdap ____/____/____ MMR ____/____/____                                        |  |                                                                          |  | Measles                   | ____/____/____ |
| Polio (IPV or OPV if before 4/1/2016) ____/____/____ Varicella ____/____/____ |  |                                                                          |  | Mumps                     | ____/____/____ |
| Hep B ____/____/____ Mening ACWY ____/____/____                               |  |                                                                          |  | Rubella                   | ____/____/____ |
| Hib ____/____/____ Hep A ____/____/____                                       |  |                                                                          |  | Varicella                 | ____/____/____ |
| PCV ____/____/____ Rotavirus ____/____/____                                   |  |                                                                          |  | Polio 1                   | ____/____/____ |
| Influenza ____/____/____ Mening B ____/____/____                              |  |                                                                          |  | Polio 2                   | ____/____/____ |
| HPV ____/____/____ Other ____/____/____                                       |  |                                                                          |  | Polio 3                   | ____/____/____ |

|                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ASSESSMENT <input type="checkbox"/> Well Child (Z00.129) <input type="checkbox"/> Diagnoses/Problems (list) ICD-10 Code | RECOMMENDATIONS <input type="checkbox"/> Full physical activity<br><input type="checkbox"/> Restrictions (specify) _____<br>Follow-up Needed <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____<br>Referral(s): <input type="checkbox"/> None <input type="checkbox"/> Early Intervention <input type="checkbox"/> IEP <input type="checkbox"/> Dental <input type="checkbox"/> Vision<br><input type="checkbox"/> Other _____ |
|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                                                               |  |                                    |  |                                                                                                            |                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------|--|------------------------------------------------------------------------------------------------------------|-------------------|
| Health Care Practitioner Signature                                                                                                                            |  | Date Form Completed ____/____/____ |  | DOHMH ONLY                                                                                                 | PRACTITIONER I.D. |
| Health Care Practitioner Name (print) Degree: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA |  | Practitioner License No. and State |  | TYPE OF EXAM: <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s)<br>Comments: |                   |
| Facility Name                                                                                                                                                 |  | National Provider Identifier (NPI) |  | Date Reviewed: ____/____/____ I.D. NUMBER                                                                  |                   |
| Address City State Zip                                                                                                                                        |  |                                    |  | REVIEWER:                                                                                                  |                   |
| Telephone Fax Email                                                                                                                                           |  |                                    |  | FORM ID#                                                                                                   |                   |

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*Reverse side of: Child & Adolescent Health Examination Form*



## Media Consent for NYC Public Schools Use

Student Name: \_\_\_\_\_

Student ID Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_

By signing below, I give permission to New York City Public Schools (NYCPS) and members of the press at NYCPS events to interview, photograph, and record audio and video of the student named above (the “Student”) and to publish the Student’s name, image, and likeness, including any photographs, audio recordings, and video recordings in print, on broadcasts, in online spaces (including websites and social media accounts), on apps, and all other forms of media. I understand that when NYCPS hosts a public event, some attendees may take their own photographs, videos, and audio at the event that capture me or my child, and that these photographs, videos, and audio may be made public.

By signing below, I also release NYCPS from all claims, demands, and liabilities in connection with the above consent.

### If Student is Under Age 18:

Name of Parent / Guardian: \_\_\_\_\_

Signature of Parent / Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

### If Student is Age 18 or Over (form must be signed by Student):

Name of Student: \_\_\_\_\_

Signature of Student: \_\_\_\_\_

Date: \_\_\_\_\_

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*Reverse side of: Media Consent for NYC Public Schools Use*

Student name \_\_\_\_\_

Class \_\_\_\_\_

Signing confirms receipt of the information below.

### CELL PHONES & PERSONAL DEVICES

If a student brings a cell phone or other personal internet-enabled device, BEES collects and secures it during the school day. Students may not use personal devices during the school day.

### UNIFORM

Students wear a BEES top with khaki bottoms and sneakers, shoes or boots. Crocs, slides and flip-flops are not permitted. BEES will support families who need uniform assistance.

### ATTENDANCE & LATENESS

Daily, on-time attendance is essential. Families should contact the school when a student will be absent or late and keep emergency contacts current.

### ARRIVAL & DISMISSAL

Breakfast begins at 8:10 a.m.; do not arrive before 8:10 a.m. Instruction begins at 8:30 a.m. and regular dismissal is at 2:50 p.m. Families must follow the dismissal plan reported to BEES.

### FAMILY INFORMATION

The supply list, school updates and resources are posted at [brooklynbees.org](http://brooklynbees.org). Families should also maintain an active NYC Schools Account (NYCSA).

☐ I received and reviewed the BEES expectations listed above.

Parent/guardian name \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_

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*Reverse side of: BEES Family Acknowledgment*



**Health  
Department**

**Public  
Schools**

**Cheryl Lawrence, MD, FAAP**  
*Medical Director*

**Office of School Health**  
**30-30 47th Ave.**  
**Long Island City, NY 11101**

August 2026

Dear Parent or Guardian,

New York City has updated the school immunization requirements for the 2026-2027 school year. A list of the vaccine requirements for the 2026-2027 school year is included with this letter. Vaccines protect children from getting and spreading diseases and are required for children to attend school. Combatting vaccine fraud in New York is a top priority to protect public health and safety and keeps children safe from vaccine-preventable diseases.

Before the school year begins, you must submit proof of immunization or blood test results that show immunity for your child if they are attending child care or school.

All students in child care to grade 12 must meet the requirements for diphtheria, tetanus and pertussis (primary/catch-up series: DTaP for children under 7 years of age or Tdap for children 7 years of older); poliovirus (IPV or OPV but OPV does not count if after April 1, 2016); measles, mumps and rubella (MMR); varicella; and hepatitis B vaccines.

Children younger than age 5 who are enrolled in child care and pre-kindergarten must also meet the requirements for the influenza (flu) vaccine (by December 31, 2026, but preferably when it becomes available in early fall) and the Haemophilus influenza type b (Hib) and pneumococcal conjugate (PCV) vaccines.

Children in grades 6 to 12 must also meet the requirements for the Tdap booster (6<sup>th</sup> grade) and meningococcal conjugate (MenACWY) vaccine (grades 7-12).

Blood tests that show immunity to MMR, varicella or hepatitis B also meet the requirements (immunity to polio only acceptable if there is immunity to all serotypes 1,2,3 and done before September 2019).

Take time this summer to review your child's immunization history with their health care provider. Your child's provider can tell you whether additional doses of one or more vaccines are required for your child to attend child care or school. Your provider can record vaccine doses on the Child and Adolescent Health Examination (CH205) form. Only providers licensed in NY, NJ or CT are authorized to complete and sign a CH205 and must be a Medical Doctor (MD), a Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), or a Nurse Practitioner (NP).

Note: If your child received vaccine doses before the minimum age (too early), those doses do not count toward the number of doses needed.

If you have questions about these 2026-2027 vaccine requirements, contact your child care center or school's administrative office.

Sincerely,

Cheryl Lawrence, MD, FAAP  
Medical Director  
Office of School Health

# Is Your Child Ready for Child Care or School?

## Learn About Required Vaccinations in New York City.

2026-2027 School Year

All students ages 2 months to 18 years in New York City must get the following vaccinations to go to child care or school. Review your child's vaccine needs based on their grade level this school year. The chart below shows the number of valid doses that are required. The number of vaccine doses your child needs may vary based on their age and previous vaccine doses received. Your child may need additional vaccines or vaccine doses if they have certain health conditions or previous doses were given too early (not valid); OPV does not count if after April 1, 2016. Blood tests that show immunity to measles, mumps and rubella, varicella, or hepatitis B also meet the requirements (immunity to polio is only acceptable if the lab test shows immunity to all 3 serotypes 1,2,3 and was done before September 2019).

| Vaccinations                                                                                               | Child Care, Head Start, Nursery, 2-K, 3-K or Pre-Kindergarten                          | Kindergarten to Grade 5                                                                                                                                                            | Grades 6 to 11                                                                                                                                           | Grade 12                                                                            |
|------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| Diphtheria, tetanus and pertussis (DTaP or Tdap for children age 7 or older) (for primary/catch-up series) | Four doses                                                                             | Five doses (or four doses only if the fourth dose was received at age 4 or older, or three doses only if the child is age 7 or older and the series was started at age 1 or older) | Three doses                                                                                                                                              |                                                                                     |
| Tetanus, diphtheria and pertussis (Tdap) booster                                                           |                                                                                        |                                                                                                                                                                                    | One dose (required at age 11 or older when entering grades 6 to 12 and in compliance until age 11)                                                       |                                                                                     |
| Polio (IPV or OPV if before April 1, 2016)                                                                 | Three doses                                                                            | Four doses (or three doses if the third dose was received at age 4 or older)                                                                                                       |                                                                                                                                                          |                                                                                     |
| Measles, mumps and rubella (MMR)                                                                           | One dose                                                                               | Two doses                                                                                                                                                                          |                                                                                                                                                          |                                                                                     |
| Hepatitis B                                                                                                | Three doses                                                                            | Three doses                                                                                                                                                                        | Three doses (or two doses of the adult hepatitis B vaccine, Recombivax HB, if the doses were received at least four months apart between ages 11 and 15) |                                                                                     |
| Varicella (chickenpox)                                                                                     | One dose                                                                               | Two doses                                                                                                                                                                          |                                                                                                                                                          |                                                                                     |
| Meningococcal conjugate (MenACWY)                                                                          |                                                                                        |                                                                                                                                                                                    | Grade 6: Not applicable<br>Grades 7 to 11: One dose                                                                                                      | Grade 12: Two doses (or one dose if the first dose was received at age 16 or older) |
| Haemophilus influenzae type b conjugate (Hib)                                                              | One to four doses<br>(depending on the child’s age and doses they previously received) |                                                                                                                                                                                    |                                                                                                                                                          |                                                                                     |
| Pneumococcal conjugate (PCV)                                                                               | One to four doses<br>(depending on the child’s age and doses they previously received) |                                                                                                                                                                                    |                                                                                                                                                          |                                                                                     |
| Influenza (flu)                                                                                            | One dose (2 <sup>nd</sup> dose if needed is not required for attendance)               |                                                                                                                                                                                    |                                                                                                                                                          |                                                                                     |

Talk to your child's health care provider if you have any questions.  
For more information, call **311** or visit [nyc.gov/health](https://nyc.gov/health) and search for **student vaccines**.



**Health  
Department**

**Public  
Schools**

### Brooklyn Environmental Exploration School

Principal Craig Garber | School Year 2026-2027 | Better Because of Us

#### CONTACT BEES

- Main Office: 718-453-3039
- 251 Macdougall Street, Brooklyn, NY 11233
- Website and supply list: [brooklynbees.org](http://brooklynbees.org)

#### DAILY SCHEDULE

- Breakfast opens at 8:10 a.m.; do not arrive before 8:10 a.m.
- Instruction begins at 8:30 a.m.
- Regular dismissal is at 2:50 p.m.

#### STAY CONNECTED

- Use your NYC Schools Account to review information and complete forms.
- NYCSA: [schoolsaccount.nyc](http://schoolsaccount.nyc)
- Keep phone, email, language and emergency contacts current.

#### HEALTH

- Send updated immunization records and health forms to the school nurse.
- Contact BEES promptly about allergies, medications or other health needs.

#### PRIVACY & FAMILY RIGHTS

- NYCPS distributes annual FERPA, PPRA and privacy notices.
- Information: [schools.nyc.gov/studentprivacy](http://schools.nyc.gov/studentprivacy)
- Paper copies and translated materials are available from BEES.

#### RETURN THE COMPLETED FORMS PROMPTLY

Keep this page and the calendar at home.

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*Reverse side of: BEES Family Quick Reference*

# School Year Calendar 2026–2027

This is the 2026–27 school year calendar for NYCPS schools from 3-K through grade 12. If your child attends a private, parochial, charter school, NYC Early Education Center (NYCEEC), or Family Childcare Program, please contact your child’s school for information about their calendar. Please note the following:

- On days when school buildings are closed due to inclement weather or other emergencies, NYCPS may be in session remotely.
- Individual schools’ Parent-Teacher Conference dates might be different from the dates below. Your child’s teacher will work with you to schedule your conference.
- On this schedule, **elementary schools** are defined as programs that serve kindergarten (K) through grade 8, including schools with 3-K and Pre-K programs, as well as those that end in grade 5 or grade 6. **Middle schools** are defined as programs that serve grades 6–8, and **high schools** are defined as programs that serve grades 9–12. **6–12 schools** are defined as programs that serve just grades 6–12 in a single school.

| Date                  | Weekday         | Event                                                                                                                                            |
|-----------------------|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>September 10</b>   | <b>Thursday</b> | <b>First day of school</b>                                                                                                                       |
| September 21          | Monday          | Yom Kippur, schools closed                                                                                                                       |
| September 23          | Wednesday       | Evening Parent-Teacher Conferences for middle schools and D75 schools                                                                            |
| September 24          | Thursday        | Evening Parent-Teacher Conferences for high schools, K–12, and 6–12 schools                                                                      |
| September 30          | Wednesday       | Evening Parent-Teacher Conferences for elementary schools and Pre-K Centers                                                                      |
| October 12            | Monday          | Italian Heritage/Indigenous Peoples' Day, schools closed                                                                                         |
| November 3            | Tuesday         | Election Day, school will be in session remotely for all students                                                                                |
| November 5            | Thursday        | Afternoon and Evening Parent-Teacher Conferences for elementary schools and Pre-K Centers; students in these schools dismissed three hours early |
| November 11           | Wednesday       | Veterans Day, schools closed                                                                                                                     |
| November 12           | Thursday        | Afternoon and Evening Parent-Teacher Conferences for middle schools and D75; students in these schools dismissed three hours early               |
| November 19           | Thursday        | Evening Parent-Teacher Conferences for high schools, K–12, and 6–12 schools                                                                      |
| November 20           | Friday          | Afternoon Parent-Teacher Conferences for high schools, K–12, and 6–12 schools; students in these schools dismissed three hours early             |
| November 26–27        | Thursday–Friday | Thanksgiving Recess, schools closed                                                                                                              |
| December 24–January 1 | Thursday–Friday | Winter Recess, schools closed                                                                                                                    |

|                   |                               |                                                                                                                                                                  |
|-------------------|-------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| January 18        | Monday                        | Rev. Dr. Martin Luther King Jr. Day, schools closed                                                                                                              |
| January 26-29     | Tuesday–Friday                | Regents Administration                                                                                                                                           |
| February 1        | Monday                        | Professional Development Day; students that attend high schools and schools that serve only grades 6-12 are not in attendance. All other students attend school. |
| February 2        | Tuesday                       | Spring Semester begins                                                                                                                                           |
| February 15–19    | Monday–Friday                 | Midwinter Recess, schools closed                                                                                                                                 |
| March 3           | Wednesday                     | Afternoon and Evening Parent-Teacher Conferences for elementary schools and Pre-K Centers; students in these schools dismissed three hours early                 |
| March 4           | Thursday                      | Afternoon and Evening Parent-Teacher Conferences for middle schools and D75 schools; students in these schools dismissed three hours early                       |
| March 9           | Tuesday                       | Eid al-Fitr, schools closed                                                                                                                                      |
| March 18          | Thursday                      | Evening Parent-Teacher Conferences for high schools, K–12, and 6–12 schools                                                                                      |
| March 19          | Friday                        | Afternoon Parent-Teacher Conferences for high schools, K–12, and 6–12 schools; students in these schools are dismissed three hours early                         |
| March 26          | Friday                        | Good Friday, schools closed                                                                                                                                      |
| April 22-30       | Thursday–Friday               | Spring Recess, schools closed                                                                                                                                    |
| May 12            | Wednesday                     | Evening Parent-Teacher Conferences for high schools, K–12, and 6–12 schools                                                                                      |
| May 13            | Thursday                      | Evening Parent-Teacher Conferences for middle schools and D75 schools                                                                                            |
| May 17            | Monday                        | Eid al-Adha, schools closed                                                                                                                                      |
| May 26            | Wednesday                     | Evening Parent-Teacher Conferences for elementary schools and Pre-K Centers                                                                                      |
| May 31            | Monday                        | Memorial Day, schools closed                                                                                                                                     |
| June 8            | Tuesday                       | Clerical Day; no classes for students attending 3-K, Pre-K, elementary schools, middle schools, K–12 schools, and standalone D75 programs                        |
| June 10           | Thursday                      | Anniversary Day/Chancellor's Conference Day for staff development; students do not attend school                                                                 |
| June 15–18; 21–25 | Tuesday–Friday; Monday–Friday | Regents Administration                                                                                                                                           |
| <b>June 28</b>    | <b>Monday</b>                 | <b>Last day of school for students</b>                                                                                                                           |