OCFS-LDSS-0792 (08/2019) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DAY CARE ENROLLMENT

PHOTO OF CHILD (Optional)	PROGRAM NAME:	ADDRESS:	PHONE NUMBER: ( ) -
	CHILD'S FULL NAME: PREFERRED NAME/NICKNAME:	DATE OF BIRTH: / /	GENDER:
	CHILD'S HOME ADDRESS:		
	NAME OF PERSON ENROLLING CHILD:	RELATIONSHIP TO CHILD: ☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative _____ ☐ Other _____	

PHONE NUMBER(S) OF PERSON ENROLLING CHILD: ( ) - ☐ ok to text EMAIL ADDRESS:	ADDRESS OF PERSON ENROLLING CHILD (IF DIFFERENT THAN CHILD):

EMERGENCY INFO	EMERGENCY CONTACT NAMES / ADDRESSES	Authorized to Pick Up Child	PRIMARY PHONE NUMBER	OTHER PHONE NUMBER / EMAIL
	PRIMARY CONTACT:	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text
		☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text
		☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text

FOR PROGRAM USE ONLY DATE OF ENROLLMENT: / /	*FOR PROGRAM USE ONLY* DATE OF DISENROLLMENT: / /

OCFS-LDSS-0792 (08/2019) REVERSE

CHILD'S FULL NAME:	DATE OF BIRTH: / /

Check boxes below to indicate if your child has any special needs/services: ☐ None

☐ Early Intervention/Special Education ☐ Occupational Therapy ☐ Speech/Language ☐ Physical Therapy

☐ Allergies (Please list) ____________________

☐ Other ____________________

Please provide information here **AND** discuss with your child care provider:

CHILD'S PRIMARY CARE PHYSICIAN'S NAME/ GROUP:	PHONE NUMBER: ( ) -
PREFERRED HOSPITAL:	PHONE NUMBER: ( ) -
CHILD'S DENTAL CARE:	PHONE NUMBER: ( ) -

Child health care information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: https://nystateofhealth.ny.gov/

AGREEMENTS

- I consent to emergency medical treatment for my child.......... ☐ Yes ☐ No
- I consent for my child to take part in neighborhood trips (i.e., library, park and playground) away from the program under proper supervision.......... ☐ Yes ☐ No
- I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips.......... ☐ Yes ☐ No
- I provided information on my child's special needs to the program to assist in caring for my child.......... ☐ Yes ☐ No
- I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation.......... ☐ Yes ☐ No
- I agree to review and update this information whenever a change occurs and at least once every year.......... ☐ Yes ☐ No

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:	DATE: / /

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CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician Assistant or Nurse Practitioner

Name of Child:	Date of Birth: / /	Date of Examination: / /

Immunizations required for entry into day care
Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s). ☐ Yes ☐ No

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	5th Date / /
Polio (IPV or OPV)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Haemophilus influenzae type B (Hib)	1st Date / /	2nd Date / /	3rd Date / /	4th Date OR 1st Date (if given on or after 15 months of age) / /	
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Hepatitis B	1st Date / /	2nd Date / /	3rd Date / /		
Measles, Mumps and Rubella (MMR)	1st Date / /	2nd Date / /			
Varicella (also known as Chicken Pox)	1st Date / /	2nd Date / /			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date: / /	Type of Immunization:	Date: / /
Type of Immunization:	Date: / /	Type of Immunization:	Date: / /
Type of Immunization:	Date: / /	Type of Immunization:	Date: / /

Tests

Tuberculin Test Date: / / Mantoux Results: ☐ Positive ☐ Negative ____ mm
TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.
If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: / / ____
Attach lead level statement
Lead Screening (Include All Dates and Results)
1 year / / Result: ____ mcg/dL ☐ Venous ☐ Capillary
2 years / / Result: ____ mcg/dL ☐ Venous ☐ Capillary
Most recent date of lead screening (if different from above):
/ / Result: ____ mcg/dL ☐ Venous ☐ Capillary

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely. If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

(Continued on reverse side)

CHILD IN CARE MEDICAL STATEMENT *(continued)*

Health Specifics		Comments
Are there allergies? (Specify)	☐ Yes ☐ No	
Is medication regularly taken? (Specify drug and condition)	☐ Yes ☐ No	
Is a special diet required? (Specify diet and condition)	☐ Yes ☐ No	
Are there any hearing, visual or dental conditions requiring special attention?	☐ Yes ☐ No	
Are there any medical or developmental conditions requiring special attention?	☐ Yes ☐ No	

Summary of Physical Exam

Include special recommendations to child day care providers

____

____

____

____

____

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care. ☐ Yes ☐ No

Signature of Examiner	Address
Please Print Name	City, State, Zip
Title	( ) - Phone / / Date

PERMISSION TO TRANSPORT

I hereby grant my child provider, MINI ME KIDDIE DAYCARE, and approved employees of the daycare to transport my child in a licensed, insured vehicle, using federal approved child safety seats and belts according to federal and state laws.

Signature of Parent/Guardian: ________________________________ Date: _______

Signature of Provider: ____ Date_______

SLEEPING ARRANGEMENT AGREEMENT

I understand that my child, ____, will sleep on a cot.

All doors to the sleeping/napping area will always remain open. If the provider is not in the same room as the children when they are sleeping, a functioning electronic monitor will be used with written parental permission.

________I will _______I will not allow my child to sleep with the provider in another room as the children with a functioning electronic monitor in use. Provider will always remain on the same floor as my child.

Signature of Parent/Guardian: ________________________________ Date: _______

Signature of Provider: ____ Date_______

SUPERVISION OF SCHOOL AGE CHILDREN

I give my permission for my school age child ______________________________, to sometimes participate in activities out of the direct visual supervision of the caregiver. Such activities will occur on the premises of the day care home. A caregiver will physically check my child every 15 minutes.

Because my child is able to toilet independently, he/she will use the bathroom for short periods of time without direct visual supervision.

Signature of Parent/Guardian: ________________________________ Date: _______

Signature of Provider: ____ Date_______

PERMISSION FROM PARENTS

If your child must use a specific brand of any of the products listed, please indicate the brand name of the product next to the category. If any brand is acceptable, just check yes or no beside the product.

___YES ___ NO Insect Repellant

___YES ___NO Sunscreen

___YES ___NO First Aid Cream/ Spray

___YES ___NO Triple Antibiotic Cream/ Ointment

___YES ___NO Neosporin

___YES ___NO Bacitracin

___YES ___NO Váseline

___YES ___NO Antiseptic Cream/ Spray

___YES ___NO Bee Sting Pads

___YES ___NO Diaper Cream

___YES ___NO Burn Cream

I ____, give permission to my child's care provider(s) to apply topical over-the-counter ointments to my child, __________________________________; according to the directions on the label. I understand that the stocked brand may be used unless I have indicated a specific brand above. This permission will be in affect from my child's start date.

Signature of Parent/Guardian: __________________________________ Date: _______

PERMISSION FROM PARENTS

PERMISSION TO USE SUNSCREEN

My child, ____________________________________ may have sunscreen applied to exposed areas when going outside on sunny days. I will provide a sunscreen with a sun protection factor (SPF) of 15 or higher (without PABA recommended), paba gives some children blotchy rashes. I will mark my child's name on his/her sunscreen PLASTIC container with a permanent marker.

Signature of Parent/Guardian: ____________________________________ Date: _______

Signature of Provider: ____ Date_______

PERMISSION TO APPLY DIAPER CREAM

My child, ______________________________ may have diaper cream applied to skin areas. I will provide diaper cream for my child. I will mark my child's name on his/her diaper cream container with a permanent marker.

______My child does NOT use diaper cream.

Signature of Parent/Guardian: ____________________________________ Date: _______

Signature of Provider: ____ Date_______

PERMISSION TO TAKE PHOTOS

My child, ____, may have their picture taken for entertainment purposes only. Photos will only be used for display in house at childcare program.

Signature of Parent/Guardian: ____________________________________ Date: _______

Signature of Provider: ____ Date_______

PERMISSION TO USE TOPICAL OINTMENTS

My child _________________________________ may have the following topical ointments used on them.

PLEASE CHECK ALL THAT APPLY:

_____ Neosporin

_____Triple Antibiotic Ointment

_____Bacitracin

_____ Vaseline

_____Alcohol Swabs

_____Other (please list here ____)

Signature of Parent/Guardian: ____________________________________ Date: _______

Signature of Provider: ____ Date_______