OCFS-LDSS-0792 (1/2005) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DAY CARE REGISTRATION

PHOTO OF CHILD (Optional)

Child's Full Name:

Does your child have any allergies? ☐ Yes ☐ No
If Yes, what is your child allergic to?

Children who have special health care needs are those who have chronic physical, developmental, behavioral or emotional conditions expected to last 12 months or more and who also require health and related services of a type beyond that required by children generally. If your child does have special health care needs please discuss these with your child-care provider.

Child's Source of Medical Care/Primary Care Physician's Name:	Telephone Number:
Child's Source of Dental Care/Dentist's Name:	Telephone Number:
Name Of Medical Care Facility/Hospital:	Telephone Number:

Would you like information on Child Health Plus? ☐ Yes ☐ No

EMERGENCY DATA

RELATIONSHIP	CONTACT NAME	TELEPHONE NUMBER DURING CHILD CARE	OTHER TELEPHONE NUMBER (Check type)
			☐ Pager ☐ Cell ☐ Other
			☐ Pager ☐ Cell ☐ Other
			☐ Pager ☐ Cell ☐ Other
			☐ Pager ☐ Cell ☐ Other

Can your child's photo be used on our web site/newspaper advertisements and articles? (yes) (no)

Provider/Day Care Facility Name and Address:

CHILD'S FULL NAME: SEX: ☐ Male ☐ Female

CHILD'S HOME ADDRESS: DATE OF BIRTH:

HOME TELEPHONE NUMBER:

DATE OF ACCEPTANCE: DATE OF DISCHARGE:

NAME OF PERSON APPLYING FOR CHILD: ☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative ☐ Other ____ HOME TELEPHONE NUMBER: DAYTIME TELEPHONE NUMBER:

ADDRESS OF PERSON LISTED ABOVE: (IF DIFFERENT FROM CHILD'S):

AGREEMENTS

I consent to the enrollment of the child listed above in this facility and have been advised of the policies regarding administration of medications, fees, transportation and the services provided by the facility, and the Office of Children and Family Services regulations under which it operates.

I give consent for my child to take part in neighborhood trips (i.e. library, park and playground) away from the facility under proper supervision. ☐ Yes ☐ No

In case of accident or injury, I authorize any and all emergency medical, dental, and /or surgical care and hospitalization advised by the physicians, surgeon or hospital (listed on the other side of this card) necessary for the proper health and well-being of my child. ☐ Yes ☐ No

I have provided information on my child's special needs (Allergies, Diet, Disabilities, and /or Medical Information) to the provider, as may be necessary to assist the facility in properly caring for my child in case of an emergency. ☐ Yes ☐ No

I agree to review and update this information whenever a change occurs and at least once every six months. ☐ Yes ☐ No

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

OCFS-LDSS-0792 (1/2005) REVERSE

ENROLLMENT INFORMATION

I, _____, would like to enroll my child, _____, at The Alphabet Tree. The Alphabet Tree will provide free lunch daily. Parents will supply one snack item (snack, juice, or milk) each week for the whole group.

My child will attend on the following days and hours:

MONDAY: from _____ to _____

TUESDAY: from _____ to _____

WEDNESDAY: from _____ to _____

THURSDAY: from _____ to _____

FRIDAY: from _____ to_____

My child's first day will be _____

My child's vacation will be (1) _____
(2) _____

Can your child's photograph be use for advertisements/newspaper articles? (yes) (no)

It is understood that I will pay $ _____**per** _____. I understand this rate will remain the same REGARDLESS OF HOLIDAYS, SICK DAYS, OR OTHER DAYS ABSENT. I will give two weeks notice (or pay for two weeks) when removing my child from care. Tuition is due on Monday before the week begins if paying weekly, or the first week of the month if paying monthly. A $10 late fee is incurred if paying more than 5 days late.

CHILD CARE RELEASE INFORMATION

The Alphabet Tree will not release your child into the custody of any person you do not specify as an acceptable pick-up person. This includes all family members (except fathers and mothers). Telephone approval is not accepted. Anyone picking up your child must have a photo ID. Please list below all persons who you would like to pick up your child. If not picked up by closing time (5:30 PM) these people may be contacted.

APPROVED PICK-UP PERSONS	PHONE NUMBER
_____	_____
_____	_____

It is understood that all mothers and fathers have equal rights to pick up their children. If you have a court order stating otherwise, it must be included in your child's records. It is understood that once a child is released into the custody of one of the above, The Alphabet Tree no longer has any responsibility for that child whatsoever. **It is the parent's responsibility to hold their child's hand and to keep the child safe in our parking lot when loading the child into and out of the car.**

I have received, read and acknowledged the written policies of the Alphabet Tree.

_____ (date) _____ (Mother's signature)

_____ (date) _____ (Father's signature)

_____ (date) _____ (Director's signature)

OCFS-LDSS-4433 (Rev. 7/2005) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

Medical Statement of Child in Childcare

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

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

Immunizations

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

DPT / DT	1st Date	2nd Date	3rd Date	Booster Date	Booster Date
Polio	1st Date	2nd Date	3rd Date	Booster Date	Booster Date
Hib (conjugate preferred)	1st Date	2nd Date	3rd Date	4th Date	
Hepatitis B	1st Date	2nd Date	3rd Date		
MMR	1st Date	2nd Date			
Varicella / Chicken Pox	1st Date	2nd Date			

Other Immunizations

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.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: _____

Attach lead level statement

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	

ADDITIONAL INFORMATION ON REVERSE SIDE →

Medical Statement of Child in Childcare (cont.)

Summary of Physical Exam

Include special recommendations to 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 day care. ☐ Yes ☐ No

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

( ) Phone

Date

Religious Exemptions

In accordance with Public Health Law, the sincere religious beliefs of the child's parents prohibit immunization. Do you wish to exercise those rights? ☐ Yes ☐ No

Any child not fully immunized for any reason must be excluded from care whenever there is an outbreak. The child may return only upon approval of the local county health department.

Signature of Parent or Person Legally Responsible

Date