

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
ENROLLMENT FORM

| | | | | | |
|---|--|--|--|-------------------------------------|-------------------------------------|
| PHOTO OF CHILD (Optional) | Child's Full Name: | | Date of Birth: / / | Gender: | |
| | Preferred Name/Nickname: | | | | |
| | Child's Home Address: | | | | |
| | Name of Person Enrolling Child: | | Relationship to Child: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Caretaker <input type="checkbox"/> Relative _____ <input type="checkbox"/> Other _____ | | |
| Phone Number(s) of Person Enrolling Child: () - <input type="checkbox"/> ok to text | | | Address of Person Enrolling Child (if different than child): | | |
| Email Address: | | | | | |
| EMERGENCY INFO | EMERGENCY CONTACT NAMES / ADDRESSES | | Authorized to Pick Up | PRIMARY PHONE NUMBER | OTHER PHONE NUMBER / EMAIL |
| | Primary Contact: | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> ok to text | <input type="checkbox"/> ok to text |
| | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> ok to text | <input type="checkbox"/> ok to text |
| | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> ok to text | <input type="checkbox"/> ok to text |
| <i>For Program Use Only</i> Date of Enrollment: / / | | | <i>For Program Use Only</i> Date of Disenrollment: / / | | |

| | | |
|---|--|--|
| Child's Full Name: | | Date of Birth: / / |
| Check boxes below to indicate if your child has any special needs/services: <input type="checkbox"/> None <input type="checkbox"/> Early Intervention/Special Education <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech/Language <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Allergies (list) _____ <input type="checkbox"/> 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 insurance 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..... | | <input type="checkbox"/> Yes <input type="checkbox"/> 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..... | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips..... | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • I provided information on my child's special needs to the program to assist in caring for my child..... | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation..... | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • I agree to review and update this information whenever a change occurs and at least once every year..... | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE: | | DATE: / / |