



Preschool & Toddler Registration Form

Child's Name: _____

Child's Birthdate: ____/____/____ Male ____ Female ____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Family email: _____

Child's Primary Care Physician's Name _____ Telephone # _____

4 Digit Code _____

Please choose a 4 digit # that will be used for dismissal.

Child's Parents or Guardians

Name and Relationship

Cell #

Employer

Work Number

Name and Relationship

Cell #

Employer

Work Number

Emergency Contacts/Approved for Pick-Up

Please list individuals other than the Parent or Guardian listed above

Contact Name	Relationship	Telephone Number During Child Care	Other Telephone Number

Agreement:

I consent to the enrollment of the child listed above in Valley Day Care Center Ltd. and have been advised of the policies, fees, and the services provided by the Center and the New York State Office of Family and Children's Services under which it operates.

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 necessary for the proper health and well-being of my child.

Signature – Parent or Person(s) legally responsible

Date

Print Name (Parent or Person(s) legally responsible)

Relationship



What Days and times are needed?

Monday_____ Tuesday_____ Wednesday_____ Thursday_____ Friday_____

Siblings name/age:

Child's Information

Does your child have any allergies? _____ If yes, please specify: _____

Does your child have any special needs? _____

What works best to calm your child if they need some extra love? _____

What is your child's favorite nursery rhyme or song? _____

What are your child's favorite things to do? _____

Is there anything you feel we should know about your child? _____



Please understand the following:

- 1) This is a **well-child** facility and we will not administer any medications. If your child is sick you agree to adhere to the exclusion policy, and/or the CDC COVID-19 guidelines.
- 2) It is impossible to deduct or makeup for any absenteeism. Days missed due to illness, vacation, or any other reason cannot be switched for a different day and will not be reimbursed.
- 3) By providing your email address you give permission for Valley Day Care to send you notes and other information via email.
- 4) Late Pick Up: If your child is picked up after their scheduled time the following will apply: Before 5pm there will be a charge of 1 hour for any part of an hour at a rate of \$15 per hour. After 5pm the late pickup fee will be \$15 per 15 minutes late.
- 5) Tuition: Due no later than the 1st of the month. If tuition is received after the 10th of the month a \$50 late fee will be applied. If you have an issue with tuition, please speak with Mr. Donohue so that we can work something out for your family in a time of need. There is a \$50 fee for all checks returned. (After 3 late payments, or 3 returned checks the fee increases to \$100)
- 6) **One Month Advanced** notice is necessary when leaving the program and one month's tuition will be charged even if not attended.
- 7) Tuition and registration fees will not be reimbursed.

I have read and agree to the above,

Print Parent/Guardian's Name

Signature



**Parent / Guardian Permission
For Staff to Apply Topical Ointment and Sunscreen**

Date: _____

Valley Day Care Center's staff members have my permission to apply to my child, when appropriate, the following over the counter topical ointments:

Please initial on the line next to each item that applies:

_____ Diaper rash ointment, supplied by parent, to be applied to diapering area as part of normal diapering routine when redness and rash is present.

_____ Antibiotic ointment, cream or other appropriate topical over the counter product used for First Aid on the affected area when a slight injury requires a first aid product be applied. *Please list any exceptions:* _____

_____ Sun Screen (on skin that is exposed to the sun before going outside during sunny weather). *Please list any exceptions, or specific instructions:* _____

I understand that if I don't allow sunscreen to be applied than my child's exposure to the sun will be limited, and that staff members will read and follow all instructions and report any unusual reactions to me (the parent/guardian).

Child's Name: _____

Parent/Guardian Name(please print): _____

Parent/Guardian Signature: _____



Napping Agreement

I agree to have my child nap on a mat provided by me in my child's classroom while s/he is in Valley Day Care Center's program.

Valley Day Care Center will directly supervise my child during nap time and if my child does not nap a quiet activity will be provided. The program will always adhere to the required ratios of caregivers to children as determined by New York State Regulations.

Parent/Guardian Name (please print)

Child's Name (please print)

Parent/Guardian Signature

Date



Picture and Video Consent/Release Form

In consideration of my desire to have my child appear in photographs or recordings, films, videotapes, or otherwise, in whatever portion you may elect to use in any medium or otherwise, and for good and other valuable consideration, I irrevocably grant to Valley Day Care the right to make such recordings and duplications and to use them or any portion thereof.

Furthermore, I specifically and irrevocably grant to Valley Day Care the right to reproduce for the public the media in which my child appears.

I release the parties and all who acquire rights – subsidiary or otherwise – from all claims which I may at any times have by reason of any such appearance or use. I attest that I make this release freely and willingly. I and all who succeed to my rights are bound by this release.

Name of Child (please print)

Parent or Guardian Name (please Print)

Address

Parent or Guardian signature

Date



When To Keep A Child Home

As we are all trying to gain some normalcy back, we must make some changes to ensure this can happen safely for all. Below are the updated guidelines for Valley Day Care and Preschool's Exclusion Policy.

Fever 100 or greater:

A child must be 72 Hours Fever Free without Tylenol/Ibuprofen before returning to childcare, or school. For example, if your child has a fever at 2pm on Monday He/She cannot return until 72 hours after the fever has broken. (The earliest return would be Friday)

If Your Child Vomits and/or diarrhea:

First time without a fever in school they must be sent home but can return the next day.

Second time in one day: If your child vomits or has diarrhea more than once in a day than they must go 24hours without vomit/diarrhea before attending school.

If a fever is present with vomiting, or diarrhea the child must be both fever and vomit/diarrhea free for 72 hours.

Colds/Coughs:

During the winter months and allergy season almost everyone gets a runny nose and a cough. However, with the development of COVID-19 and the inability to differentiate we must exclude anyone with a persistent cough from the center. Please keep your child home if they have a persistent cough as they will not be permitted in.

Please use your judgement and if your child has any of the following please keep them home:

- large amounts of mucus from their nose (green or yellow typically indicates infection)
- sneezing a lot
- Severe ear pain or fluid coming from the ear



NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES
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: _____ / /
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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)	1 st Date / /	2 nd Date / /	3 rd Date / /	4 th Date / /	5 th Date / /
Polio (IPV or OPV)	1 st Date / /	2 nd Date / /	3 rd Date / /	4 th Date / /	
Haemophilus influenzae type B (Hib)	1 st Date / /	2 nd Date / /	3 rd Date / /	4 th Date OR 1 st Date (if given on or after 15 months of age) / /	
Pneumococcal Conjugate (PCV) for those born on or after 1/1/08)	1 st Date / /	2 nd Date / /	3 rd Date / /	4 th Date / /	
Hepatitis B	1 st Date / /	2 nd Date / /	3 rd Date / /		
Measles, Mumps and Rubella (MMR)	1 st Date / /	2 nd Date / /			
Varicella (also known as Chicken Pox)	1 st Date / /	2 nd 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.			



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
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