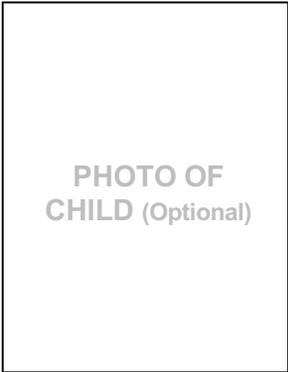


NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
DAY CARE ENROLLMENT



PROGRAM NAME: Karen's Castle Inc.	ADDRESS: 81 Glenwood Rd., Glen Head, 11545	PHONE NUMBER: (516) 674-3834
CHILD'S FULL NAME: PREFERRED NAME/NICKNAME:		DATE OF BIRTH: / /
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 Child	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"/> 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

FOR PROGRAM USE ONLY DATE OF ENROLLMENT: / /	FOR PROGRAM USE ONLY DATE OF DISENROLLMENT: / /
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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 (Please 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 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 |..... 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 |..... Yes No
- I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field |..... Yes No
- I provided information on my child's special needs to the program to assist in caring for my |..... Yes No
- I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by |..... Yes No
- I agree to review and update this information whenever a change occurs and at least once every |..... Yes No

SIGNATURE - PARENT OR PERSON(S) LEGALLY RESPONSIBLE:	DATE: / /
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CHILD CARE EMPLOYEE, VOLUNTEER, PARENT, CHILD AND ESSENTIAL VISITORS HEALTH SCREENING ONE-TIME ATTESTATION

Before entering a child care program, employees, volunteers, parents, children and essential visitors ***must complete a health screening questionnaire daily. In addition, each employee, volunteer, parent, child and essential visitor must sign and submit this form to the program one time.***

Employees, volunteers, parents, children and essential visitors must answer all questions and take their temperature daily to confirm a body temperature lower than 100.0 degrees Fahrenheit. If anyone answers "Yes" to any of the questions below, they cannot enter the child care program. A parent or guardian is responsible for completing daily screening on behalf of their child(ren).

Self-Screening:

Below are the self-screening questions that employees, volunteers, parents, children and essential visitors are required to answer **daily**. If any of the answers to the below questions are "Yes," individuals **cannot** enter the program. If the answers are "No" to all the following questions, individuals may enter the program. If employees, volunteers, parents, children and essential visitors cannot take their temperature at home, but answer "No" to all other questions, they may report to the program to have their temperature taken on site.

1. Is your temperature higher than or equal to 100.0 degrees Fahrenheit?
2. Have you had any known contact with a person confirmed or suspected to have COVID-19 in the past 14 days?
3. Are you currently experiencing ANY of the following symptoms?
 - Cough (new or worsening)
 - Shortness of breath (new or worsening)
 - Trouble breathing (new or worsening)
 - Fever
 - Chills
 - Muscle pain (new or worsening)
 - Headache (new or worsening)
 - Sore throat (new or worsening)
 - New loss of taste
 - New loss of smell
4. Have you tested positive for COVID-19 through a diagnostic test in the past 14 days?

If you have answered "NO" to all questions, you have passed and may enter the program. If you have answered "YES" to any question, you will not be allowed to enter the program.

Attestation: By signing this document, I agree that I will self-monitor these symptoms each day and report the outcome per the instructions above and will not enter any child care program if any of the above symptoms or conditions are present.

	/ /
Signature	Date
	/ /
Signature	Date

Note: This document must be signed and returned to the program prior to entry. A signed copy needs to be provided only once. The child care program must retain a copy for their records.

Both Parents / Guardians Must Sign