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| PHOTO OF CHILD (Optional) | | NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES DAY CARE ENROLLMENT | | | | |
| | | 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: <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"/> 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 | | | FOR PROGRAM USE ONLY | | | |
| DATE OF ENROLLMENT: / / | | | 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 (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 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: / / |

