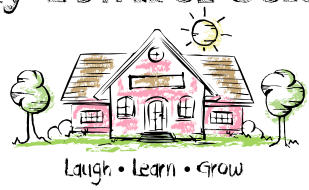
Tiny Town of Colonie



COVID 19 POLICY

Updated 5/9/2022

Ensuring the health and safety of everyone within our program remains our top priority. This policy provides information on our expectations and requirements as a program during the current COVID-19 pandemic. Please keep in mind that the guidance is constantly changing. It is the responsibility of each member of our program to remain knowledgeable on the current guidelines and always exercise caution if there is a question of whether it is safe to send your child to program.

You are required to notify the center Director if any of the following situations occur:

1. The child in care requires COVID testing
2. A member of the household requires COVID testing
3. A member of the household is under precautionary or mandatory quarantine
4. A member of the household has tested positive for COVID
5. A family is notified that a child has been exposed at another program (local school, extracurricular activity, camp, etc.)

Per our current Parent Handbook payment is due on Monday of each week in order to remain in good standing with the program. Families are entitled to (1) vacation week at half pay each enrollment year. If the program would need to close due to a COVID related exposure or if a family is required to quarantine, the family may choose to utilize their (1) week at half pay (must be used towards a full week Monday to Friday).

As of May 9, 2022, if an individual tests POSITIVE all children who have been exposed within the previous 48 hours will be required to quarantine for a minimum of 5 days. Children able to effectively wear a well-fitted mask will be able to return to program on Day 6 if they have remained symptom free. A mask must be worn through Day 10 of exposure. If a child develops symptoms within the 10 days following exposure, a negative test will be required to return. Symptoms include fever, runny nose, cough, excessive tiredness, vomiting, diarrhea, and any other symptom listed on the CDC website.

Note: Classrooms will be closed for 1 day following a positive case to clean and sanitize

Child's Name: _____

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

OCFS-6040 (Rev. 06/2021)

NEW YOK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

COVID-19 HEALTH SCREENING ATTESTATION

The New York State Department of Health Interim Guidance for Child Care Programs requires all individuals to complete a daily health screening questionnaire before arriving to a child care program or upon arrival to a child care program.

If an individual answers “Yes” to any of the screening questions, they cannot enter the child care program, except as otherwise indicated.

Screening Questions:

1. Is your temperature higher than or equal to 100.4 degrees Fahrenheit?

2. Have you had any known close or proximate contact with a person confirmed (by diagnostic test) or suspected (based on symptoms) to have COVID-19 in the past 10 days? Note: Close contact is defined by DOH as being within 6 feet of an individual for 10 minutes or more within a 24-hour period, starting from 2 days before symptom onset or, if asymptomatic, 2 days before the date the positive sample was collected through when they are isolated. Close contact does not include individuals who work in a health care setting wearing appropriate, required personal protective equipment.

Exception: Asymptomatic staff and children may attend if the staff/child is fully vaccinated or has recovered from laboratory confirmed COVID-19 in the previous 3 months and has not been placed on quarantine. Note: Fully vaccinated is defined as being 2 weeks or more after either receipt of the second dose in a 2 dose vaccine series, or 2 weeks or more after receipt of one dose of a single-dose vaccine.

3. Are you currently experiencing or have you recently, (within the past 10 days) experienced ANY COVID-19 symptoms?

Note: *Symptoms may occur with pre-existing medical conditions, such as allergies or migraines. You should only answer "Yes" if your symptoms are new or worsening.*

- Cough
- Shortness of breath
- Trouble breathing
- Fever (equal to or above 100.4 degrees Fahrenheit)
- Chills
- Muscle pain or body aches
- Headache
- Sore throat
- Loss of taste or smell
- Fatigue
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

4. Have you tested positive for COVID-19 through a diagnostic test within the past 10 days?

5. Have you traveled within the past 10 days and not complied with requirements of the New York State Travel Advisory?

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

X	/ /
Signature	Date
X	/ /
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.*

Authorization to Release Child from Program

I permit Tiny Town of Colonie to release my child _____ from child care to the adults listed below in the event that I cannot be reached in cases of sickness and/or emergency.

Name _____

Address _____

Contact Number _____

Relation to child _____

Name _____

Address _____

Contact Number _____

Relation to child _____

Name _____

Address _____

Contact Number _____

Relation to child _____

Parent/Guardian Signature _____
Date_____

-Adult must provide valid form of identification
-This form MUST be updated annually

OCFS-LDSS-0792 (08/2019) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DAY CARE ENROLLMENT

PHOTO OF CHILD (Optional)

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: ☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative _____ ☐ Other _____	
PHONE NUMBER(S) OF PERSON ENROLLING CHILD: ( ) - ☐ ok to text EMAIL ADDRESS:	ADDRESS OF PERSON ENROLLING CHILD (IF DIFFERENT THAN CHILD):	

EXAMPLE

EMERGENCY INFO

EMERGENCY CONTACT NAMES / ADDRESSES	Authorized to Pick Up Child	PRIMARY PHONE NUMBER	OTHER PHONE NUMBER / EMAIL
PRIMARY CONTACT:	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text
	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text
	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text

FOR PROGRAM USE ONLY	*FOR PROGRAM USE ONLY*
DATE OF ENROLLMENT: / /	DATE OF DISENROLLMENT: / /

OCFS-LDSS-0792 (08/2019) REVERSE

CHILD'S FULL NAME:	DATE OF BIRTH: / /

Check boxes below to indicate if your child has any special needs/services: ☐ None

☐ Early Intervention/Special Education ☐ Occupational Therapy ☐ Speech/Language ☐ Physical Therapy

☐ Allergies (Please list) _____

☐ 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..... ☐ 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 supervision..... ☐ Yes ☐ No
- I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips..... ☐ Yes ☐ No
- I provided information on my child's special needs to the program to assist in caring for my child..... ☐ Yes ☐ No
- I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation..... ☐ Yes ☐ No
- I agree to review and update this information whenever a change occurs and at least once every year..... ☐ Yes ☐ No

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

NAPPING POLICY AND AGREEMENT

In accordance with New York State regulations, Tiny Town of Colonie and _____ have agreed to the following napping arrangements for _____.

Please check the following:

Child will nap/rest on an individual _____ Crib _____ Nap Mat

Per our regulations, infants/children may not sleep in swings, strollers or infant bouncy seats. Should a child fall asleep he/she must be moved to a crib/nap mat in an approved sleeping space.

An infant will be placed on their backs to sleep, unless a note signed by the infant's doctor recommends different sleeping arrangements.

For children unable to nap, a time and space must be provided for quiet rest/play. Children will not be forced to sleep or rest for long periods of time.

Parent Signature _____ Date _____

Provider Signature _____ Date _____

OCFS-LDSS-4433 (Rev. 06/2019)

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: / /

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)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	5th Date / /
Polio (IPV or OPV)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Haemophilus influenzae type B (Hib)	1st Date / /	2nd Date / /	3rd Date / /	4th Date **OR** 1st Date (if given on or after 15 months of age) / /	
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Hepatitis B	1st Date / /	2nd Date / /	3rd Date / /		
Measles, Mumps and Rubella (MMR)	1st Date / /	2nd Date / /			
Varicella (also known as Chicken Pox)	1st Date / /	2nd 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.

(Continued on reverse side)

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

Title

( ) - Phone

/ / Date

PHOTOGRAPHY AND SOCIAL MEDIA USE

I, _____, give Tiny Town of Colonie permission to use photographs and videos of my child/children for public use. I understand that the images may be used in print publications, online publications, presentation, websites and social media.

Child's Name: _____

Child's Name: _____

Child's Name: _____

-OR-

I, _____, prefer that Tiny Town of Colonie DOES NOT use photographs and videos of my child/children for public use.

Parent Signature: _____ Date: _____

Provider Signature: _____ Date: _____

OCFS- 6020 (3/2015)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

TRANSPORTATION PLAN

Child Day Care Programs

Provider Name: Kristen Blais Facility ID Number: 864729

Program Name: Tiny Town of Colonie

Effective Date of Transportation Plan: 9 / 14 / 2020

This form may be used to document the program's Transportation Plan. The plan is designed to promote the safety of children and inform families of regulatory requirements regarding transportation. The parent will be asked to sign a separate Transportation Consent Form (OCFS 6013).

1. The Program will obtain written consent from the parent(s) for any transportation of their child provided for, or arranged by a caregiver, and will keep the transportation policy and the written parental consent on file at the program, and parents can be given a copy.

2. A child will never be left unattended in any motor vehicle or other form of transportation.

3. Every child will board or leave a vehicle from the curb side of the street.

4. Each child will be secured in safety seats or safety belts as required by law. Safety seats will be supplied by: (who)
   N/A

5. Drivers will be 18 years of age or older and hold a current valid license to drive the class of vehicle they are operating. All vehicles used to transport children must have a current registration and inspection sticker.

6. The parent(s) will be provided a copy of this plan at enrollment. If the plan changes, the parent(s) will be provided a copy of the amended transportation plan, prior to its start date. The use of cell phones or any other electronic device during transport, including hand-free devices, is prohibited. Necessary calls will be made once the vehicle is parked in a legally permitted position off the road.

7. The Program will display daily transportation schedules at the following locations: (where)
   Located at the front door.

8. During the transport of children, the program will adhere to the required ratio of caregivers to children at all times as determined by regulations.

9. When a child is released from the program, the program will verify that the individual approved by the parent(s) to receive the child is present at the designated drop off location. If the approved person is not present as planned the parent(s) will be contacted immediately by the Program.

10. The parent will be able to check the posted daily transportation schedule regarding transportation arrangements for each day a child is in care. Other Comments:

OCFS 6013 (2/2015)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

TRANSPORTATION CONSENT FORM

Child Day Care Programs

Provider Name: Kristen Blais Facility ID Number: 864729

Program Name: Tiny Town of Colonie

This form may be used to meet the regulatory requirement to obtain written consent from the parent of a child for any transportation provided or arranged for by a caregiver, and to inform the parent when the person who is providing transportation changes. This form is not the Transportation Plan.

Parents whose children receive transportation services must receive, at the time of enrollment of their children, a copy of the program's transportation plan. If the plan is amended, parents must receive a copy of the amended plan prior to its start date.

It is recommended that a separate Transportation Consent Form be completed for each child.

☒ I have been informed of, and agree to, the transportation plan of the above child care program.

Transportation Plan is attached to this Transportation Consent Form (Yes / No) *circle one*

Date of Transportation Plan 09/14/2020

☒ I give permission for my child *(name)* _____

to be transported by *(caregiver names and/or transportation contractor arranged for by the program)* By a staff member of Tiny Town of Colonie.

At the following times *(check all that apply)*:

☐ Only as recorded on the posted transportation schedule for my child

☒ Other *(explain)* If the school bus for some reason does not show up, a Tiny Town of Colonie Staff member will transport your child to their school.

By signing this form I am giving consent for the above described transportation services.

Parent Printed Name: _____

Parent Signature: **X** _____

Date _____

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ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, indicated below **(Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____

For Official Use Only

Date Received
Employee Signature

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