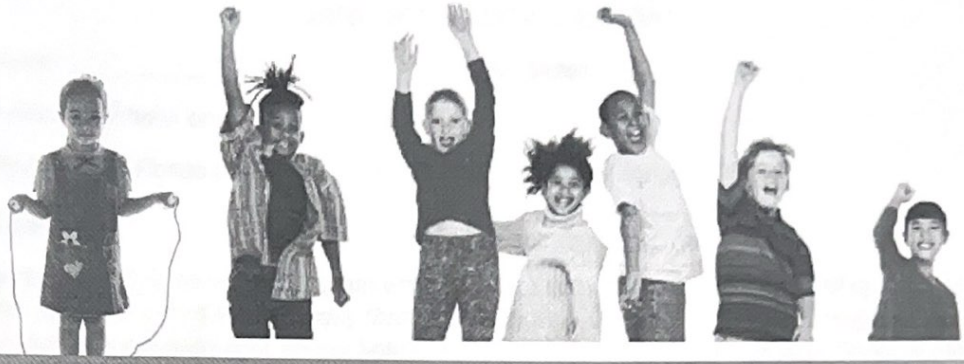
Caring Hands of Yonkers



2024-2025 School Age Program
Registration Packet

Khalil Gibran School
18 Rosedale Road
Yonkers, NY 10710

School 30
30 Nevada Place
Yonkers, NY 10708

Program Director: Madeline Ramos
914-720-3283
caringhandsofyonkers@yahoo.com

Caring Hands of Yonkers

2020 - 2021 PARENT CONTRACT

Childs's Name: _____ ***Start Date:*** _____

Program Location *(check one):*

( ) ***School 28*** *(18 Rosedale Road)* ( ) ***School 30*** *(30 Nevada Place)*

Hours of Operation

- *The 2022-2023 School Age Program will begin on September 12, 2022 and will operate until June 22, 2023. Services are offered Monday through Friday from 3:00 pm - 6:00 pm throughout the academic year, with the exceptions of school holidays. Pease review the Yonkers Public Schools calendar for more information on school closure dates.*

Enrollment Options & Program Fees

- ***Our program provides full-time and part-time enrollment options:***
  - Full-Time - $140.00 per week
  - Part-Time - $110.00 per week (Up to 3 days per week) - part time enrollment must be arranged before your child begins the program. Otherwise a full-time fee will be charged.
- A $25.00 non-refundable registration is also required to complete the registration.
- *In addition, all children must be picked-up by 6:00pm each day. Any child who remains in our care past 6:00pm, will be charged a fee of $20.00 per half hour.*
- Invoices will be sent via QuickBooks by the final week of the current month for the month ahead. Please keep in mind that the monthly amount due can vary from month to month , as we charge for services on a weekly basis and the number of weeks can fluctuate each month.
- *Payments can be made for the monthly amount due or on a weekly basis. However, payment will be required the week before any services are rendered. Outstanding balances will result in a late fee of $15 each week payment us overdue and may lead to suspension of services until payment is received.*
- *Payment can be provided by paper check or electronically (credit card or ACH bank transfer) via QuickBooks. You also have the option of enrolling in automatic payment by filling out a one time credit card? ACH bank transfer authorization form (form enclosed).*
- *No refunds, credit or discounts are provided for temporary absence due to illness, inclement weather or any other circumstances. However, children who are enrolled part-time may make up the day they missed in the event the program is closed due to a school holiday.*
- *All checks and money orders should be made payable to Caring Hands of Yonkers. Please include a notation of your child's name, as this will help ensure that funds are routed into the proper account.*

Caring Hands of Yonkers

Homework Policy

- *Our program schedule allows children 60 minutes for homework completion each day.*
- *Please be advised that you have the option to opt out of completing their homework while in our care.*
- *We are also happy to accommodate caregivers who prefer to increase the amount of time their children spend on homework each day.*
- *We will help with remote assignments if the child has their tablet of laptop.*
- *Please indicate your homework preference below by checking one of the following options:*
    - *I agree to the standard program structure of 60 minutes of homework each day.*
    - *I prefer that my child spend an extra ____ minutes on homework each day.*
    - *I prefer that my child* **does** *not complete their homework during program hours.*

Additional Details and Requirements

- We will adhere to the COVID protocols mandated by Center for Disease Control and Prevention (CDC), New York State Office of Children and Family Services (OCFS) and Yonkers Public Schools. Additional information can be provided upon request.
- *All parents or designated persons signing children out will need to provide picture identification. Please note: only individuals listed on the emergency card will be allowed sign out children.*
- A copy of your child's updated immunization record is required in order to complete the registration process. In addition, new registrants are required to provide a copy of their latest physical.
- In the event of inclement weather, *Caring Hands Of Yonkers will adhere to any Yonkers Public Schools closures.*
- *I understand that Caring Hands Of Yonkers, Inc. is an independent licensed provider and is not part of Yonkers Public Schools.*
- *The program director, Madeline Ramos, can be reached at (914) 720-3283*

I agree to the terms and conditions noted above.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Parent/Guardian Phone Number: _____

Email: _____

Date: _____

OCFS-LDSS-0792 (08/2019) FRONT

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

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: / /

Caring Hands of Yonkers

CONSENT TO PHOTOGRAPH, FILM, OR VIDEOTAPE

I certify that I am the parent/ guardian of _____.

Child's Name

I understand that Caring Hands of Yonkers may periodically take pictures of children and video footage for usage in future marketing materials. This information will only be used to promote the programs and services offered by Caring Hands of Yonkers.

In addition, I understand that Caring Hands of Yonkers may feature special events. Caring Hands of Yonkers, media representatives, newspaper and television reporters, photographers, and various other public relations personnel may be present at these special events to record them. In some cases, they may interview and/or photograph children who participate in these events.

Please check one:

- I hereby consent to the participation in interviews, the use of quotes, and the taking of photographs, movies or video tapes of the child named above by Caring Hands of Yonkers I also grant to the right to edit, use, and reuse said products and/or photographs/videos taken for marketing purposes including use in print, on the internet, and all other forms of media.

- I DO NOT give permission for my child to be photographed or otherwise recorded during summer day camp activities and events. As a result, my child may not be able to participate in certain events and activities.

Parent/Guardian Name: _____ Parent/Guardian 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) / /	
Pneumococcal 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