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):	

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: / /

Child Care Discipline Policy

Policy Statement

Praise and positive reinforcement are effective methods of behavior management of children. When children receive positive, nonviolent, and understanding interactions from adults and others, they develop good self-concepts, problem solving abilities, and self-discipline. Based on this belief, _____ uses a positive approach to discipline and practices the following discipline and behavior management techniques.

WE DO

- Communicate to children using positive statements.
- Communicate with children on their level.
- Talk with children in a calm quiet manner.
- Explain unacceptable behavior to children.
- Give attention to children for positive behavior.
- Praise and encourage the children.
- Reason with and set limits for the children.
- Apply rules consistently.
- Model appropriate behavior.
- Set up the classroom environment to prevent problems.
- Provide alternatives and redirect children to acceptable activity.
- Give children opportunities to make choices and solve problems.
- Help children talk out problems and think of solutions.
- Listen to children and respect the children's needs, desires and feelings.
- Provide appropriate words to help solve conflicts.
- Use storybooks and discussion to work through common conflicts.

WE DO NOT

- Inflict corporal punishment in any manner upon a child. (Corporal punishment is defined as the use of physical force to the body as a discipline measure. Physical force to the body includes, but is not limited to, spanking, hitting, shaking, biting, pinching, pushing, pulling, or slapping.)
- Use any strategy that hurts, shames, or belittles a child.
- Use any strategy that threatens, intimidates, or forces a child.
- Use food as a form of reward or punishment.
- Use or withhold physical activity as a punishment.

- Shame or punish a child if a bathroom accident occurs.
- Embarrass any child in front of others.
- Compare children.
- Place children in a locked and/or dark room.
- Leave any child alone, unattended or without supervision.
- Allow discipline of a child by other children.
- Criticize, make fun of, or otherwise belittle a child's parents, families, or ethnic groups.

Conferences will be scheduled with parents if particular disciplinary problems occur. If a child's behavior consistently endangers the safety of the children around him/her, then the Director has the right, after meeting with the parents and documenting behavior problems and interventions, to terminate child care services for that particular child.

Note: If, at any point, there is an indication/suspicion that a child may have special needs, _____ will inform the child's family and make contact with Baby Net for assessment and assistance.

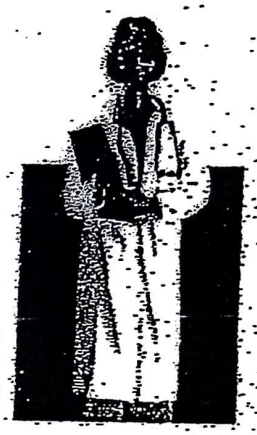
My signature below indicates that I have received a copy of the discipline policy, it has been reviewed with me, and I have read and understand this policy.

Signature_____ **Date**_____

Please circle as appropriate: STAFF PARENT

If parent, name of child_____

EMERGENCY MEDICAL CONSENT



I (we) the parent of _____

give my (our) consent for the provider,

_____ to seek medical attention if an emergency should occur and I (we) cannot get to my (our) child in a reasonable time. If necessary, I (we) ask that the ambulance be called if the illness or injury warrants it. I (we) agree, for the health and welfare of my (our) child that the provider use his/her judgment.

_____ _____

Parent(s) name date

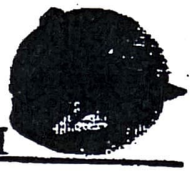
_____ _____

Parent(s) signature date

_____ _____

Provider signature

OUT DOOR ACTIVITY PERMISSION FORM



The provider and staff

of_____ may take my

child _____for short walking

trips and any of the activities checked below as

part of the Family/Group Family Day Care

Program.

( ) Providers' back yard

( ) Neighborhood Park

( ) Other _____

Parent/Guardian (print)

_____Date__/__/__

SLEEPING AND NAPPING AGREEMENT
Family Day Care and Group Family Day Care

Sleeping and napping arrangements must be made in writing between the parent and the child care provider. The provider shall maintain this completed agreement on file in the child care home. This arrangement is required by New York State Child Day Care Regulations [Family Day Care 417.7 (i) and 417.8 (a) (1), and Group Family Day Care 416.7 (i) and 416.8 (a) (1)].

I, (parent name) _____, understand that my child(ren),

_____, while under the care of (child care provider)

_____, will be napping on a (bed/cot/mat/chair)

_____ in the (baby room/main room)_____ of the child care home.

My napping child will have competent supervision at all times, either through:

(Please check one box below)

☐ Direct supervision by a caregiver who is in the same room and has direct visual contact with him/her;

OR

☐ Indirect supervision by a caregiver who uses a functioning electronic monitor and remains on the same floor as my child at all times. The doors to all rooms where children are napping must remain open, as well as the doors to all rooms used by the provider.

If my child is an infant, I also understand that my child will be placed on his/her back to sleep.

Parent's Signature:

Name (please print): _____ Signature: _____

Date: _____ (Month/Day/Year)

Child Care Provider's Signature:

Name (please print): _____ Signature: _____

Date: _____ (Month/Day/Year)

Pick Up Authorization

I(we) the parent(s) of _____ give my(our) consent for the following individual(s) to pick up my(our) child if I(we) are unable to do so.

Name:	Address:	Phone#

The following individual(s)are not allowed to pick up my (our) child.

1. _____
2. _____

_____ Date:_____

Parent(s) signature

_____ Date:_____

Provider Signature

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

Medical Statement of Child in Childcare

To Be Completed By Licensed Physician, Physician's Assistant or Nurse Practitioner

Name of Child:	Date of Birth:	Date of Examination:

Immunizations required for entry into day care ☐ Yes ☐ No

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).

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.

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.

ADDITIONAL INFORMATION ON REVERSE SIDE ➔

Medical Statement of Child in Childcare

(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 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 day care. ☐ Yes ☐ No

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

( ) Phone

Date

Religious Exemptions

Public Health law Section 2164 allows a child to be religiously exempted from immunization. A written and signed statement from a parent, parents or guardian of the child stating that they object of the immunization of their child due to their sincere and genuine religious beliefs should be submitted to the day care owner, operator or administrator who shall determine whether the statement of religious belief is acceptable.

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | Sex ☐ Female ☐ Male | Date of Birth (Month/Day/Year) ___/___/____

Child's Address | Hispanic/Latino? ☐ Yes ☐ No | Race (Check ALL that apply) ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other

City/Borough | State | Zip Code | School/Center/Camp Name | District ___ Number ___

Phone Numbers: Home | Cell | Work

Health Insurance (including Medicaid)? ☐ Yes ☐ No | ☐ Parent/Guardian ☐ Foster Parent | Last Name | First Name | Email

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

Attach MAF if in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF):* ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) _____

Explain all checked items above. ☐ ***Addendum attached.***

Medications *(attach MAF if in-school medication needed)*

☐ None ☐ Yes *(list below)*

_____

PHYSICAL EXAM Date of Exam: ___/___/___

Height _____ cm (___ ___ %ile)

Weight _____ kg (___ ___ %ile)

BMI _____ kg/m² (___ ___ %ile)

Head Circumference *(age ≤2 yrs)* _____ cm (___ ___ %ile)

Blood Pressure *(age ≥3 yrs)* _____ / _____

General Appearance:

☐ Physical Exam WNL

	NI	Abnl
Psychosocial Development	☐	☐
Language	☐	☐
Behavioral	☐	☐
HEENT	☐	☐
Dental	☐	☐
Neck	☐	☐
Lymph nodes	☐	☐
Lungs	☐	☐
Cardiovascular	☐	☐
Abdomen	☐	☐
Genitourinary	☐	☐
Extremities	☐	☐
Skin	☐	☐
Neurological	☐	☐
Back/spine	☐	☐

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

Validated Screening Tool Used? ☐ Yes ☐ No — Date Screened ___/___/___

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: _____

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< 1 year ☐ Breastfed ☐ Formula ☐ Both

≥ 1 year ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes *(list below)*

SCREENING TESTS	Date Done	Results
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	___/___/___	_____ µg/dL
	___/___/___	_____ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	___/___/___	☐ At risk *(do BLL)* ☐ Not at risk

— Child Care Only —

Hemoglobin or Hematocrit	___/___/___	_____ g/dL _____ %

Hearing

	Date Done	Results
< 4 years: gross hearing	___/___/___	☐ NI ☐ Abnl ☐ Referred
OAE	___/___/___	☐ NI ☐ Abnl ☐ Referred
≥ 4 yrs: pure tone audiometry	___/___/___	☐ NI ☐ Abnl ☐ Referred

Vision

	Date Done	Results
<3 years: Vision appears:	___/___/___	☐ NI ☐ Abnl
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right ___/___ Left ___/___ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental

Visible Tooth Decay ☐ Yes ☐ No

Urgent need for dental referral *(pain, swelling, infection)* ☐ Yes ☐ No

Dental Visit within the past 12 months ☐ Yes ☐ No

CIR Number

Physician Confirmed History of Varicella Infection ☐

Report only positive immunity:

IMMUNIZATIONS – DATES

DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Tdap	___/___/___	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	MMR	___/___/___	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Varicella	___/___/___	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Mening ACWY	___/___/___	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Hep A	___/___/___	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Rotavirus	___/___/___	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Mening B	___/___/___	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Other _____	___/___/___	___/___/___

	IgG Titers	Date
Hepatitis B		___/___/___
Measles		___/___/___
Mumps		___/___/___
Rubella		___/___/___
Varicella		___/___/___
Polio 1		___/___/___
Polio 2		___/___/___
Polio 3		___/___/___

ASSESSMENT ☐ **Well Child** (Z00.129) ☐ **Diagnoses/Problems** *(list)* — **ICD-10 Code**

_____ _____

_____ _____

_____ _____

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions (*specify*) _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: ___/___/___

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other _____

Health Care Practitioner Signature | Date Form Completed ___/___/___

Health Care Practitioner Name and Degree *(print)* | Practitioner License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone | Fax | Email

DOHMH ONLY PRACTITIONER I.D.

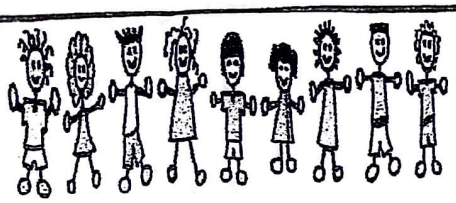
TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Date Reviewed: ___/___/___ **I.D. NUMBER**

REVIEWER:

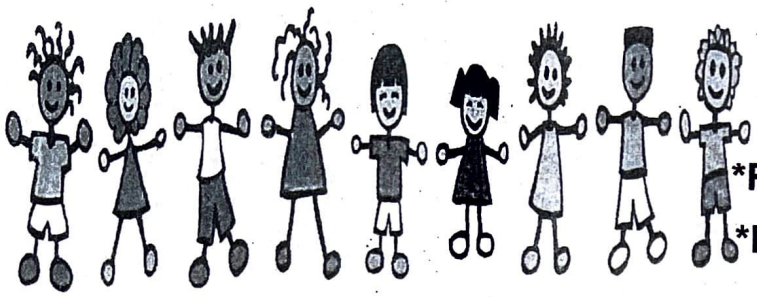
FORM ID#



Tal...Tal...Daycare/Preschool

DAILY SCHEDULE

8.00-8.45	Arrival-table Toys/Clean Up
8.45-9.00	Good Morning Greetings
9.00-9.05	Wash Hands
9.05-9.25	Breakfast
9.25-9.35	Music and Movements
9.35-9.45	Circle Time
9.45-11.05	Centers
11.10-11.15	Clean Up
11.15-11.45	Gross Motor/Indoor & Outdoor
11.45-11.55	Story Time/Read Aloud
11.55-12.00	wash Hands
12.00-12.30	Lunch Time
12.30-1.00	Washing Hands
1.00-2.30	Rest Time
2.30-3.00	Clean Up Cots
3.00-3.15	PM Snack
3.15-3.20	Wash Hands
3.20-3.35	Centers
3.35-3.45	End Of The Day Circle Time
3.45-4.00	Dismissal



Tali Bazon 347-924-5141
*Star Class 718-263-2384
*Rainbow Class 718-627-6091
*Blue Sky Class 516-965-0239

Tal...Tal... Daycare/Pre-School

Please remember to hand in the following items on our Parents' Teachers' conference day.

* 2 Wet Wipes

* Change of cloths (Including socks and underwear)

* A Sheet

* A Blanket

* 3 bounty (paper towels)

* 2 tissue boxes

* 2 boxes of Big Zip Lock bags

- 1 Pack of computer papers

- Plastic Folder

- Hand Sanitizer

Everything should be labeled !!!!!!

Meals	Monday	Tuesday	Wednesday	Thursday	Friday
AM SNACK BREAKFAST	Cold Cereal (unsweetened) Apples 1%, skim (ages 2+) / whole (ages 1-2)	Cottage/Ricotta Cheese Bread Whole Grain Apples Mixed Vegetables 1%, skim (ages 2+) / whole (ages 1-2)	Cottage/Ricotta Cheese Bread Whole Grain Apples Mixed Vegetables 1%, skim (ages 2+) / whole (ages 1-2)	Cold Cereal (unsweetened) Apples 1%, skim (ages 2+) / whole (ages 1-2)	Cottage/Ricotta Cheese Bread Whole Grain Apples Mixed Vegetables 1%, skim (ages 2+) / whole (ages 1-2)
Lunch	Chicken Legs (thighs/ wings) Rice (WG) Peas and Carrots Mixed Vegetables	Fish (any) Pasta Whole Grain - Any Peppers-Red, Yellow, Green Tomato Paste/Sauce	Beef Ground Rice (WG) Tomato Paste/Sauce Apples	Cottage/Ricotta Cheese Bread Whole Grain Egg Mixed Vegetables Apples	Turkey Lean Bread Whole Grain Mixed Vegetables Apples
PM SNACK	Cottage/Ricotta Cheese Crackers (Any) Whole Grain Cucumbers Bananas 1%, skim (ages 2+) / whole (ages 1-2)	Cottage/Ricotta Cheese Crackers (Any) Whole Grain Tomatoes Apples 1%, skim (ages 2+) / whole (ages 1-2)	Cottage/Ricotta Cheese Crackers (Any) Whole Grain Mixed Vegetables Bananas 1%, skim (ages 2+) / whole (ages 1-2)	Cottage/Ricotta Cheese Crackers (Any) Whole Grain Mixed Vegetables Bananas 1%, skim (ages 2+) / whole (ages 1-2)	Cottage/Ricotta Cheese Crackers (Any) Whole Grain Mixed Vegetables Apples 1%, skim (ages 2+) / whole (ages 1-2)