

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

<p>PHOTO OF CHILD (Optional)</p>	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: / /
<p>Check boxes below to indicate if your child has any special needs/services: <input type="checkbox"/> None</p> <p> <input type="checkbox"/> Early Intervention/Special Education <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech/Language <input type="checkbox"/> Physical Therapy </p> <p> <input type="checkbox"/> Allergies (Please list) _____ </p> <p> <input type="checkbox"/> Other _____ </p> <p>Please provide information here AND discuss with your child care provider:</p>	
CHILD'S PRIMARY CARE PHYSICIAN'S NAME/ GROUP:	PHONE NUMBER: () -
PREFERRED HOSPITAL:	PHONE NUMBER: () -
CHILD'S DENTAL CARE:	PHONE NUMBER: () -
<p>Child health care information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: https://nystateofhealth.ny.gov/</p>	
AGREEMENTS	
<ul style="list-style-type: none"> • 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: / /