

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

<p>PHOTO OF CHILD (Optional)</p>	Child's Full Name:		Date of Birth: / /	Gender:	
	Preferred Name/Nickname:				
	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	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
<i>For Program Use Only</i> Date of Enrollment: / /			<i>For Program Use Only</i> 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> <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 (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: () -
<p>Child health insurance information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: https://nystateofhealth.ny.gov/</p>		
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: / /