**OCFS-LDSS-0792** (10/2018) FRONT

|  | NEW YORK STATEOFFICE OF CHILDREN AND FAMILY SERVICES**DAY CARE ENROLLMENT** |
| --- | --- |
| 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 . Ookoo((oiiiioo.. ≠9+)>999☐ No + (jo ookokookiooooo{oooo{ooooooooooooooo{oo{{ |        ☐ ok to text |        ☐ ok to text |
| *ooo* | *For Program Use Only*Date of Disenrollment:       /       /       |

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**Lkk. Okay poofggbg-gggtLkklmkOCFS-LDSS-0792** (10/2018) 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 (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 insurance 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……………………………………………………………………………. ● I consent for my child to take part in neighborhood trips (i.e., library, park and playground) away from the program under proper supervision………………………………………………………………………………………………………………. ● I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips.…………………………………………………………………………………………………. ● I provided information on my child’s special needs to the program to assist in caring for my child…………………………… ● I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation………………………………………………………………………………………………………………….. ● I agree to review and update this information whenever a change occurs and at least once every year…………………….  | ☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes | ☐ No☐ No☐ No☐ No☐ No☐ No |
| SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE: | DATE:      /       /       |