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

|  | | NEW YORK STATE  OFFICE 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:       /       / | | | |

8

**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:       /       / | | | |