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

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

# DAY CARE ENROLLMENT

PHOTO OF CHILD (Optional)

| | | |
|---|---|---|
| Child's Full Name:<br>Preferred Name/Nickname: | Date of Birth:<br>/ / | Gender: |
| Child's Home Address: | | |
| Name of Person Enrolling Child: | Relationship to Child:<br>☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative ____<br>☐ Other ____ | |
| Phone Number(s) of Person Enrolling Child:<br>( ) - ☐ ok to text<br>**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*<br>Date of Enrollment: / / | *For Program Use Only*<br>Date of Disenrollment: / / |

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

| | |
|---|---|
| Child's Full Name: | Date of Birth:<br>/ / |

**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:<br>( ) - |
| Preferred Hospital: | Phone Number:<br>( ) - |
| Child's Dental Care: | Phone Number:<br>( ) - |

**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…… ☐ 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:<br>/ / |