**OCFS-LDSS-0792** (08/2019) FRONT

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| **PHOTO OF CHILD (Optional)** | NEW YORK STATEOFFICE OF CHILDREN AND FAMILY SERVICES**DAY CARE ENROLLMENT** |
| 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:[ ]  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 [ ]  No  | (     )       -      [ ]  ok to text | (     )       -      [ ]  ok to text      |
| ***For Program Use Only***Date of Enrollment:       /       /       | ***For Program Use Only***Date of Disenrollment:       /       /       |

**OCFS-LDSS-0792** (08/2019) REVERSE

|  |  |
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| 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 (Please 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 care 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:      /       /       |