

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

PHOTO OF CHILD (Optional)	PROGRAM NAME:		ADDRESS:		PHONE NUMBER: () -		
	CHILD'S FULL NAME:				DATE OF BIRTH: / /		
	PREFERRED NAME/NICKNAME:				GENDER:		
	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 Child	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	
FOR PROGRAM USE ONLY				FOR PROGRAM USE ONLY			
DATE OF ENROLLMENT: / /				DATE OF DISENROLLMENT: / /			

CHILD'S FULL NAME:		DATE OF BIRTH: / /	
Check boxes below to indicate if your child has any special needs/services: <input type="checkbox"/> None			
<input type="checkbox"/> Early Intervention/Special Education		<input type="checkbox"/> Occupational Therapy	
<input type="checkbox"/> Allergies (Please list) _____		<input type="checkbox"/> Speech/Language	
<input type="checkbox"/> Other _____		<input type="checkbox"/> Physical Therapy	
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.....			<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: / /