Care2Learn Daycare

Director: Rose Mendez

www.care2learndaycare.com

caretwolearn@gmail.com

3152 Villa Ave.

Bronx, N.Y. 10468

917-658-9349

Licensed by Department of Health

Experienced and Certified Teacher

Ages: 2 months through 4 years

Year-round program 8:00am-6:00pm

Flexible hours and days

Educational activities

Hours of fun!

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CARE 2 LEARN DAYCARE

Guardian Guidelines

1. **Arrival and Departure**: Upon arrival and departure, signing in and out must be done daily. Given is a daily health check.

2. **Hours**: Hours of operation are 8:00AM-6:00PM. No acceptance after 10:00 AM. Your child must be picked up at the appointed time. A $1.00 a minute will be imposed to defray the cost of overtime.

3. **Shoes**: Shoes must be removed or covered before entering the center. No flipflop or sandals permitted. We highly recommend sneakers. Shoes must not fit the child big or small; it must fit properly.

4.**Release Policy**: No child released under any circumstances to anyone you have not previously authorized. On filed should be the person's name, address, and telephone number. Photo ID is required.

5. **Photograph**: Before being photographed guardian must sign a consent form. Photos will be sent to parents via email and used for program promotion as needed.

6. **Immunization**: It is required by the New York State to submit age-appropriate vaccination of the child. Please bring proof at the child's start date. It is vital that all children are vaccinated to prevent the spread amongst other children.

7. **Illness**: We value the health of the staff and children. Your child must be kept at home if: Fever over 100.4, vomiting, rash or head lice, diarrhea, eye infection, sore throat, not feeling well, thick green mucus, flu or a virus, measles, mumps, rubella, chicken pox, severe coughing, ringworms, or trouble breathing. A doctor's note must be submitted before a child can return to the daycare. The person listed under "emergency contact" must be reachable.

8.**Make-up**: Part-Time children have three weeks to make up the hours on a given day. If absent is not due to illness, the day cannot be made -up. A doctor's note is required if absent two days or more. A full-time child is not able to make-up days if absent due to illness.

9.**Injuries**: we will notify you of any injury if serious; otherwise you will be informed at your arrival at days end.

10.**Medication**: we are not allowed to administer any medication. A guardian may enter the center if medication is needed.

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11.**Meals**: We participate in a food program. As long as we participate in this program, provided are the meals at no cost to the guardian. Meals consist of breakfast, lunch, and dinner. Families are responsible for filling out a U.S.D.A form to be enrolled in the program. If you refuse to participate, the guardian must provide all meals and drink for their child.

12.**Requirement**: You are required to bring a crib sized fitted and flat sheet (if staying for nap), a spill-proof cup, diapers or pull-ups (must be able to open in the sides), wipes, Kleenex, napkins, extra set of clothes (including socks and underwear), and a favorite item if any. Please mark every garment with your child's name, Including coats, sweaters, and backpacks. We do not want to place it into someone else's bag accidentally.

13.**Personal Belongings**: Children have a difficult time sharing with others. Even harder with their unique toys. We have plenty of toys. Keep yours at home. We are not responsible for toys that are lost or damaged.

14.**Toilet Training**: Children who are ready to be toilet trained will gently be encouraged. We need your help with encouraging them at home.

15.**Trips**: Guardians will be informed ahead of time concerning any field trips. Permission slips must be filled out. We ask the guardian to keep the child home for the day if you choose not to let the child attend.

16.**Tuition**: It is mandatory that we get paid on time. The full tuition is due the first of each month or the agreed upon designed day. We will not give monetary credit for absence, emergency closing, holidays, mandatory training, staff, or parents vacation. To maintain our low child-teacher ratio, we must maintain a steady income. A non-refundable security deposit is due upon enrollment. The last month of registration it will be utilized.

17.**Vacation**: Payment must be in full before going away. So, your child is guaranteed a slot when they return. Attached you will see a listing of Holidays and events that will take place.

18.**Concerns**: If you need to speak to the director, please send an email. We will set a meeting to discuss your concerns. (independenttots@gmail.com)

19.**Terminate Contract**: A month's notice by the guardian or director is required for termination of this contract.

Guardian's Signature_____________________________ Date_____________

Director's Signature _____________________________ Date______________

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Care 2 Learn Daycare

Contract

I ______________________ (Guardian's name) have received and read the Guardian Guidelines, and agree to comply with all rules and regulations as stated. This contract is valid beginning; Date: __________. One month notice by either party will be required in order to terminate this contract.

I am expected to pay full rates for holidays, absences, emergency closing, mandatory training, staff, or guardian's vacation. Added will be additional charges to damages to the center's properties.

I agree to enroll my child _________________ age ______ at Care 2 Learn Daycare and agree to pay a non- refundable security deposit equal to half the months tuition. My child's last month of enrollment, the security deposit will be accredited.

Please circle the days and enter the time your child will attend.

Monday _____ Tuesday _____ Wednesday _____ Thursday ______ Friday ______

Tuition: _________ Security Deposit: __________

All fees must be paid before admission. A child who does not complete the month will not be given a refund. I understand that payments will be made by the first of each month.

Guardian's Signature: ___________________________ Date: ___________

Director's Signature: ____________________________ Date: ___________

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Care 2 Learn Daycare

Admission Application

Child of whom placement is requested:

Name: ____________________ Nickname: _______________ Age:_______ Birth Date__________
Address: _____________________________ Apt: _____ City: ______ State: _____Zip:__________
Sex: F or M Sibling: _____________________Age:______ _______________________ Age: ______

Guardian's Information:

Mother's Name: _________________________
Address: _____________________________
Cell # ________________________________
Work Place: ___________________________
Address: _____________________________
Telephone: ___________________________
Email: _______________________________

Father's Name: _________________________
Address: _____________________________
Cell # ________________________________
Work Place: ___________________________
Address: _____________________________
Telephone: ___________________________
Email: _______________________________

Health for child:

Doctor's name: ___________________
Address: ________________________

Insurance: _______________________________
Telephone: _______________________________

Any health problems or operation: Yes or No
If yes, please explain ____

Any allergies to food or medication: Yes or No
If yes, please explain ____

Are there any activities you refuse your child from doing: Yes or No
If yes, please explain ____

Has your child had previous child care placement: Yes or No
If yes, reason for leaving ____

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The person authorized to pick-up child (must be filled completely)

Name: ______________________ Address: ______________________
Relationship: ______________________ Telephone #: ______________________

Name: ______________________ Address: ______________________
Relationship: ______________________ Telephone #: ______________________

(only names listed above will be authorized to pick the child up) (photo ID required).

Emergency Contact

Name: ______________________ Address: ______________________
Relationship: ______________________ Telephone #: ______________________

Name: ______________________ Address: ______________________
Relationship: ______________________ Telephone #: ______________________

(If the guardian can't be reached the person listed above must be reachable and available to pick the child up). (if needed).

Care 2 learn daycare consent form

I hereby give permission to Rose Mendez and/or Staff to take my child ______________
On neighborhood walks, parks, library, sprinklers, and trips, etc. I understand this is part of their schedule or educational program.

Guardian's signature: ______________________ Date: ______________
Director's Signature: ______________________ Date: ______________

Napping Arrangement

Rose Mendez/Staff will supervise my child ______________________ while napping on a mat in the Livingroom of the childcare center. if my child is an infant, they will be placed on its back to sleep.

Guardian's Signature: ______________________ Date: ______________
Director's Signature: ______________________ Date: ______________

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NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

NON-MEDICATION CONSENT FORM

Child Day Care Programs

- This form may be used when a parent consents to having over-the-counter products administered to their child in a child day care program. These products include, but are not limited to: topical ointments, lotions and creams, sprays, sunscreen products and topically applied insect repellant.
- This form should NOT be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays. OCFS Form 7002 would meet the consent requirements for medications.
- One form must be completed for each over-the-counter product. Multiple products cannot be listed on one form.
- This form must be completed in a language in which the staff is literate.
- If parent's instructions differ from the instructions on the product's packaging, permission must be received from a health care provider or licensed authorized prescriber.

PARENT TO COMPLETE THIS SECTION (#1 - #14)

1. Child's first and last name:
2. Date of birth:
3. Child's known allergies:
4. Name of product (including strength):
5. Amount to be administered:
6. Route of administration:

7A. Frequency to be administered, include times of day if appropriate: ______

OR

7B. Identify the conditions that will necessitate administration of the product (signs and symptoms must be observable prior to administration): ______

8A. Possible side effects: ☐ See product label for complete list of possible side effects (parent must supply)

AND/OR

8B: Additional side effects: ______

9. What action should the child care provider take if side effects are noted:

☐ Contact parent ______

Other (describe): ______

10A. Special instructions: ☐ See package insert for complete list of special instructions (parent must supply)

AND/OR

10B. Additional special instructions: ______

11. Reason(s) for use (unless confidential by law): ______

12. Parent name (please print):

13. Date authorized:

14. Parent signature:

X

DAY CARE PROGRAM TO COMPLETE THIS SECTION (#15 - #21)

15. Program name:
16. Facility ID number:
17. Program telephone number:

18. I have verified that #1, -#14 are complete. My signature indicates that all information needed to administer this product has been given to the child day care program.

19. Staff's name (please print):

20. Date received from parent:

21. Staff's signature:

X

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Care 2 Learn Daycare

Medical Consent

I hereby consent Care 2 Learn Daycare and staff to take any steps necessary to care for the health of my child, ______________________ date of birth ____________

should any emergency arise.

I understand that it may be necessary for the staff to act on my behalf in getting the needed medical attention. I also agree that I will be financially responsible for any costs due to emergency medical treatment.

Email address: ________________________________

Guardian's name: ________________________ Cell # ______________________

Guardian's Signature __________________________ Date ____________

Director's Signature __________________________ Date ____________

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Care 2 Learn Daycare

Over the counter ointment

Child's name ______________________ D.O.B ________________

I ________________________, (Guardian's name) give Rose Mendez and Staff permission to apply the following.

Diaper rash _________________ (name of ointment) to be applied ____times a day.
Sunscreen _________________ (name of lotion) to be applied ____ times a day.
Insect repellent _________________ (name of repellent) to be applied ____ times a day.

The guardian will provide the products.

Additional notes:

____
____
____

Guardian's Signature: ______________________ Date: __________

Director's Signature: ______________________ Date: __________

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Care 2 Learn Daycare

Photograph consent form

I, _________________________ (Guardian's name), hereby consent to the taking of photograph(s) and or video(s) of my child, ______________________ (child's name). Whom is currently enrolled at Care 2 Learn Daycare. I understand the photos and or videos is to promote the childcare. The photos and videos will be in print and on-line publication, website, and social media. I also understand that no royalty, fee, or other compensation shall become payable to me by reason of such use.

[ ] I consent to my child being photographed and (or) being videoed.

[ ] I do not consent my child to being photographed and (or) videoed.

Guardian's Signature: ____________________________ Date: _______________

Director's Signature: ____________________________ Date: _______________

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NEW YORK STATE DEPARTMENT OF HEALTH
Child and Adult Care Food Program

Child Enrollment Form
for Day Care Homes

Parent or Guardian completes form

Provider # ____________

Name of Day Care or Owner/Operator ____________

On-Site Provider *(if different)* ____________

Child's Name ____________ DOB ____________ ☐ Male ☐ Female

Child's Name ____________ DOB ____________ ☐ Male ☐ Female

Child(ren)'s Ethnic Information *(Choose one option per child)*

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Child(ren)'s Racial Information

☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander

☐ White ☐ Black or African American

Check if any of these apply

☐ Provider's Resident Child ☐ Child is related to Provider ☐ Child of Migrant Farm Worker ☐ Disabled ☐ Foster Child

HOURS/DAYS/MEALS Date Care Begins ____________

Time Care Begins ____________ Time Care Ends ____________

Time Care Begins ____________ Time Care Ends ____________

Days child normally receives care

☐ Mon-Fri *OR* ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun

Meals child normally receives in care ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ LN Snack

Holiday and/or weekend care ☐ Yes ☐ No Time Care Begins ____________ Time Care Ends ____________

Does child(ren) attend school ☐ Yes ☐ No Name of School ____________

Does child receive care on non-school days? ☐ Yes ☐ No

INFANT FEEDING STATEMENT *(must be completed for any child less than one year of age)*

☐ The Parent will supply breastmilk or formula ☐ The Parent will supply ALL infant's food

☐ The Provider will supply formula ☐ The Provider will supply infant's food

CONTACT INFORMATION FOR PARENT/GUARDIAN – to be completed by Parent/Guardian

Parent/Guardian's Name ____________ Email Address ____________

Parent/Guardian's Name ____________ Email Address ____________

Home Address ____________

Home Phone Number ____________ Work/Cell Phone Number ____________

Parent/Guardian Signature ____________ Date ____________

FOR SPONSOR USE ONLY
Date Enrollment Begins ____________ Date Enrollment Expires ____________ Child Enrollment Approved ____________ INITIALS

This institution is an equal opportunity provider.

White: Sponsor Canary: Provider

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CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | Sex ☐ Female ☐ Male | Date of Birth *(Month/Day/Year)* ___/___/______

Child's Address | Hispanic/Latino? ☐ Yes ☐ No | Race *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other ______

City/Borough | State | Zip Code | School/Center/Camp Name | District Number ___ | Phone Numbers Home ______ Cell ______ Work ______

Health insurance (including Medicaid)? ☐ Yes ☐ No | ☐ Parent/Guardian ☐ Foster Parent | Last Name | First Name | Email

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: ______ weeks gestation

☐ Complicated by ______

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* ______

☐ Foods *(list)* ______

☐ Other *(list)* ______

Attach MAF if in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF)*: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) ______

Explain all checked items above. ☐ *Addendum attached.*

Medications *(attach MAF if in-school medication needed)* ☐ None ☐ Yes *(list below)*

PHYSICAL EXAM Date of Exam: ___/___/___

Height ______ cm (___ %ile)
Weight ______ kg (___ %ile)
BMI ______ kg/m² (___ %ile)
Head Circumference *(age ≤2 yrs)* ______ cm (___ %ile)
Blood Pressure *(age ≥3 yrs)* ______ / ______

General Appearance:

☐ Physical Exam WNL

Nl	Abnl		Nl	Abnl		Nl	Abnl		Nl	Abnl		Nl	Abnl	
☐	☐	Psychosocial Development	☐	☐	HEENT	☐	☐	Lymph nodes	☐	☐	Abdomen	☐	☐	Skin
☐	☐	Language	☐	☐	Dental	☐	☐	Lungs	☐	☐	Genitourinary	☐	☐	Neurological
☐	☐	Behavioral	☐	☐	Neck	☐	☐	Cardiovascular	☐	☐	Extremities	☐	☐	Back/spine

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

Validated Screening Tool Used? ☐ Yes ☐ No — Date Screened ___/___/___

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: ______

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< 1 year ☐ Breastfed ☐ Formula ☐ Both

≥ 1 year ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes *(list below)*

SCREENING TESTS	Date Done	Results
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	___/___/___	______ µg/dL
	___/___/___	______ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	___/___/___	☐ At risk *(do BLL)* ☐ Not at risk
— Child Care Only —		
Hemoglobin or Hematocrit	___/___/___	______ g/dL ______ %

Hearing	Date Done	Results
< 4 years: gross hearing	___/___/___	☐ Nl ☐ Abnl ☐ Referred
OAE	___/___/___	☐ Nl ☐ Abnl ☐ Referred
≥ 4 yrs: pure tone audiometry	___/___/___	☐ Nl ☐ Abnl ☐ Referred

Vision	Date Done	Results
<3 years: Vision appears:	___/___/___	☐ Nl ☐ Abnl
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right ___/___ Left ___/___ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental		
Visible Tooth Decay	☐ Yes	☐ No
Urgent need for dental referral *(pain, swelling, infection)*	☐ Yes	☐ No
Dental Visit within the past 12 months	☐ Yes	☐ No

CIR Number ☐☐☐☐☐☐☐☐☐☐

Physician Confirmed History of Varicella Infection ☐

IMMUNIZATIONS – DATES

DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	

Tdap	___/___/___	___/___/___	___/___/___
MMR	___/___/___	___/___/___	___/___/___
Varicella	___/___/___	___/___/___	___/___/___
Mening ACWY	___/___/___	___/___/___	___/___/___
Hep A	___/___/___	___/___/___	___/___/___
Rotavirus	___/___/___	___/___/___	___/___/___
Mening B	___/___/___	___/___/___	___/___/___
Other ______	___/___/___	___/___/___	___/___/___

Report only positive immunity:

IgG Titers	Date
Hepatitis B	___/___/___
Measles	___/___/___
Mumps	___/___/___
Rubella	___/___/___
Varicella	___/___/___
Polio 1	___/___/___
Polio 2	___/___/___
Polio 3	___/___/___

ASSESSMENT ☐ Well Child (Z00.129) ☐ Diagnoses/Problems *(list)* — ICD-10 Code

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions *(specify)* ______

Follow-up Needed ☐ No ☐ Yes, for ______ Appt. date: ___/___/___

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other ______

Health Care Practitioner Signature | Date Form Completed ___/___/___

Health Care Practitioner Name and Degree *(print)* | Practitioner License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone | Fax | Email

DOHMH ONLY — PRACTITIONER I.D. ☐☐☐☐☐☐☐

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Date Reviewed: ___/___/___ — I.D. NUMBER ☐☐☐☐☐☐☐

REVIEWER:

FORM ID# ☐☐☐☐☐☐☐☐☐☐☐☐☐

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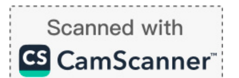

Care-2-Learn Childcare

Daily Schedule

A.M

8:00 -10:00	Arrival, health check, wash hands, diaper check/bathroom time Free choice (all areas are open)
9:30 -10:00	Wash hands and serve breakfast
10:00-10:30	Group time: singing, finger play, reading (current interest and theme)
10:30-11:40	Activity time accordingly to our theme: art, dramatic play, water or Sand table, shapes, numbers, letters, concept games, music Movement or outdoor recreation
11:40-11:55	Bathroom time/diaper check, wash hands

P.M

12:00-12:30	Serve lunch
12:30-1:00	Story time
1:00- 2:45	Nap time (for children, who refuse to nap or wake up before others, Quiet activities are available, such as books, puzzles, and concepts Games)
2:45- 2:55	Wake-up time, diaper check/bathroom time, wash hands
3:00- 3:30	Serve snack
3:30-4:00	Afternoon group time: singing, finger play, reading
4:00- 5:00	Story time & calm activities (coloring, sensory bins, matching cards)
5:00-5:45	free choice, ends of the day

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OCFS-LDSS-0792 (08/2019) FRONT

NEW YORK STATE
OFFICE 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

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........ ☐ 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: / /

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