

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

PHOTO OF CHILD (Optional)	Child's Full Name:		Date of Birth:	Gender:
	Preferred Name/Nickname:		/ /	
	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:				
EM ER GE NC Y INF O	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 Date of Enrollment: / /			For Program Use Only 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"/> Speech/Language <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Allergies (list) _____ <input type="checkbox"/> 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	
<ul style="list-style-type: none"> • 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:

/ /