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

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PHOTO OF CHILD (Optional)** | | 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…………………………………………………………………………….  ● 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:       /       / | | |