NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

# DAY CARE ENROLLMENT

| PROGRAM NAME: | ADDRESS: | PHONE NUMBER: ( ) - |
|---|---|---|

| CHILD'S FULL NAME:<br>PREFERRED NAME/NICKNAME: | DATE OF BIRTH: / / | GENDER: |
|---|---|---|

CHILD'S HOME ADDRESS:

| NAME OF PERSON ENROLLING CHILD: | RELATIONSHIP TO CHILD:<br>☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative _____<br>☐ Other _____ |
|---|---|

| PHONE NUMBER(S) OF PERSON ENROLLING CHILD:<br>( ) - ☐ ok to text<br>**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***<br>DATE OF ENROLLMENT: / / | ***FOR PROGRAM USE ONLY***<br>DATE OF DISENROLLMENT: / / |
|---|---|



| 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: / / |
|---|---|

**COLUMBIA GREENE COMMUNITY COLLEGE DAY CARE CENTER**

Child's Name: _____

Date of Birth: _____

## Fall 2023

The Day Care Center is open 7:30 AM. To 5:00 PM. Monday through Thursday and Fridays 7:30 AM to 4:00 PM in accordance with the college schedule.

In order for your child to be considered for admission into the Day Care Center, this application, completed in full with all forms filled out and signed, must be returned to the Day Care Center prior to the date you want your child to start.

| Days | In | Out | Total Hours | Office Use Only | |
|---|---|---|---|---|---|
| Monday | | | | 15 | |
| Tuesday | | | | 17 | |
| Wednesday | | | | 16 | |
| Thursday | | | | 16 | |
| Friday | | | | 16 | |

Total Contract _____

Office Use only

Student _____
Staff _____
Community _____

# Parent Schedule

**Name** **Semester**

| Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|
| 8:00-8:55 | 8:00-9:20 | 8:00-8:55 | 8:00-9:20 | 8:00-8:55 |
| 9:05-10:00 | 9:30-10:50 | 9:05-10:00 | 9:30-10:50 | 9:05-10:00 |
| 10:10-11:05 | 11:00-12:20 | 10:10-11:05 | 11:00-12:20 | 10:10-11:05 |
| 11:15-12:10/12:35 | 12:30-1:50 | 11:15-12:10/12:35 | 12:30-1:50 | 11:15-12:10/12:35 |
| 12:45-1:40/2:05 | 2:00-3:20 | 12:45-1:40/2:05 | 2:00-3:20 | 12:45-1:40/2:05 |
| 2:15-3:35 | 3:30-4:50 | 2:15-3:35 | 3:30-4:50 | 2:15-3:35 |
| 3:45-5:05 | | 3:45-5:05 | | 3:45-5:05 |
| | | | | |

**COLUMBIA GREENE COMMUNITY COLLEGE DAY CARE CENTER**

Child's Name: _____

Parent/Legal Guardian's Name: _____

**FEE AGREEMENT**

I have enrolled my child in the Columbia Greene Community College Day Care Center. I understand the fee for Day Care is computed for the semester and is due and payable on the first day of the week my child is in the center. I also understand the fee is non-refundable. I therefore agree to pay the current market rate at the time stated. I understand that I will be held solely responsible for payment of child care charges accrued during my child's enrollment at Columbia Greene Community College Day Care Center.

_____ _____

Parent/Legal Guardian Signature Date

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**STUDENT/PARENTS FINANCIAL AID RELEASE FORM**

I give my permission to the CGCC Day Care Center to access my financial aid funds to cover all or a portion of the Day Care tuition for my child. I understand that if there are no financial aid funds available, I am responsible for the entire balance.

For any future change, a written request must be submitted to the Day Care office prior to the second week of the semester.

_____ _____

Parent/Legal Guardian Signature Date

Student ID # _____

Will you graduate by the end of the current academic year? _☐_ Yes _☐_ No

**COLUMBIA GREENE COMMUNITY COLLEGE DAY CARE CENTER**

# Child's Information

Child's Name: _____ DOB: _____

Place of Birth: _____ Home Phone: _____

Home Address: _____

# Father's Information

Name: _____ Birth Place: _____

Address: _____

Home Phone #: _____ Cell Phone #: _____

Email: _____

Employer Name: _____ Work Phone #: _____

# Mother's Information

Name: _____ Birth Place: _____

Address: _____

Home Phone #: _____ Cell Phone #: _____

Email: _____

Employer Name: _____ Work Phone #: _____

# Emergency Information

Name of a LOCAL person to be contacted in case of emergency who can take physical custody of your child when parent cannot be reached. They must also be on the pick up list.

_____ Phone #: _____

Name of child's physician: _____

Address: _____ Phone #: _____

Does your child have any unusual physical condition of which we should be aware? Use back of sheet if necessary. _____

_____

_____

_____

_____

# Columbia-Greene Community College Day Care Center

Child's Name: _____

Parent/Legal Guardian's Name: _____

## TRANSPORTATION PICK-UP / DROP OFF

I give my permission to have my child transported to and/or from Columbia-Greene Community College Day Care Center by the following person or persons:

| Name | Relationship | Phone Number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Please note: Persons on your pick up list will be contacted for pick-up in an emergency situation when primary emergency person can not for some reason be reached. Your primary emergency person must also be on this pick-up list.

_____ _____

Parent/Legal Guardian Signature Date

**Columbia-Greene Community College Day Care Center**

Child's Name _____

Names, ages and relationships of all of your child's brothers and sisters.

| Name | Sex | Date of Birth | School Grade | Relationship |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Other members of your child's usual household:

| Name | Relationship to Child | Name | Relationship to Child |
|---|---|---|---|
| | | | |
| | | | |

Use back of sheet if necessary.

What is child's reaction when left by parent_____

_____

Marital status of parent: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

Have there been any changes in the family group, such as death or divorce? Please explain._____

_____

List communicable diseases child has had._____

_____

List any other serious illnesses, operations or accidents since birth._____

_____

_____

As far as you know will your child be able to participate fully in the program at the Day Care Center. If not please explain adjustments that will be needed. _____

_____

_____

Does your child show a preference for his/ her right or left hand?_____

As a rule, your child's appetite is: ☐ excellent ☐ good ☐ fair ☐ poor

**Columbia-Greene Community College Day Care Center**

Child's Name _____

Does your child have any allergies? Please describe:

Food _____

Medication _____

Other [soap, animals ,etc.] _____

Does your child need help in taking care of his/ her eliminations?_____

Does your child usually nap? ☐ Y ☐ N For how long? _____ When? _____

Does your child have any particular fears? [dogs, sirens, etc.] Please describe: _____

_____

_____

Does your child enjoy any particular toys or games? Please describe: _____

_____

_____

Are there additional circumstances regarding your child that you would like us to be aware of? Please explain:_____

_____

_____

Is your child happy playing alone? ☐ Y ☐ N Does he/she have imaginary playmates? ☐ Y ☐ N

Please describe these playmates._____

_____

Does your child encounter any difficulties in play situations? ☐ Y ☐ N If so please explain:

_____

Has your child attended school in the past? ☐ Y ☐ N Please list the name of the school and the length of time they attended _____

_____

Please list any traditional holidays you prefer that your child not participate in:

_____

Please describe your child's usual behavior and personality: _____

_____

Please describe the usual methods used to control your child's behavior. Indicate which methods have been most useful. _____

_____

What is your child's usual reaction to discipline? _____

_____

What things repeatedly cause conflict between parent and child? _____

_____

# Columbia-Greene Community College Day Care Center

Child's Name: _____

Parent/Legal Guardian's Name: _____

## TRIP PERMISSION:

I give my child permission to participate in all campus based trips planned by the Columbia Greene Community College Day Care Center.

Parent/Legal Guardian Signature: _____

Date: _____

## MEDICAL CARE PERMISSION:

I give the Columbia Greene Community College Day Care Center permission to obtain emergency medical care for my child, and to use whatever transportation that is available.

Parent/Legal Guardian Signature: _____

Date: _____

**NOTE:** In the event of an accident or emergency, every attempt will be made to notify the child's parent and physician immediately.

## PERMISSION FOR APPLICATION OF LOTIONS, CREAMS AND SPRAYS

I give permission for Day Care Staff or Teachers to apply over-the counter topical ointments, lotions, creams and sprays including first aid creams, sunscreen, insect repellent and hand lotion to my child. I understand that I am to provide the hand lotion, sunscreen and insect repellent of choice and it must be labeled with my child's first and last name on it. I also understand that I have to give it to my child's teacher and not leave it in the cubby area.

Parent/Legal Guardian Signature: _____

Date: _____

## COLUMBIA GREENE COMMUNITY COLLEGE DAY CARE CENTER

Child's Name: _____

Parent/Legal Guardian's Name: _____

### OBSERVATION PERMISSION

I give permission for my child to be observed by academic and non-academic visitors to the center. I understand my child will be observed by non-Center personnel for teaching or training purposes. I give permission for my child to participate in observation projects conducted by those authorized by the Director. I give permission for my child to participate in research or testing as approved by the center Director in connection to student course observation.

Parent/Legal Guardian Signature: _____

Date: _____

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### PHOTOGRAPH RELEASE

I give permission for my child to be photographed, tape recorded or videotaped by Day Care or College staff when involved in Center activities, including campus based field trips. Such materials may be used for classroom and/or publicity purposes and may be posted on the CGCC Day Care Facebook page.

Parent/Legal Guardian Signature: _____

Date: _____

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### SURVEY

I give permission for my child to participate in surveys that are connected to gaining information for grants and other areas of concern to Day Care on all levels [Local, State and Federal]

Parent/Legal Guardian Signature: _____

Date: _____

**Columbia-Greene Community College Day Care Center**

**POLICIES AND PROCEDURES**

1. Children may not come to Day Care when they are sick.

2. Each child must have a complete change of clothing in his or her cubby labeled with his or her name.

3. Children are not to be dropped off at Day Care before their scheduled time, unless prearranged with the office.

4. All children must be picked up at their scheduled times. Day Care will bill the parent for the salaries of the employee required to stay for any child not picked up on time.

5. All Day Care accounts must be kept up to date at least one week in advance.

6. Parents are to notify Day Care when their child is going to be absent.

7. Parents who want their child to come as a drop in must check with the director in advance.

8. We try to go out for play EVERY day. Please dress your child appropriately.

9. Children are to wear rubber soled shoes or sneakers every day. Clogs and sandals are not permitted and snow boots must be changed before entering the classroom. All of this is for safety reasons.

10. Please do not bring your child to the Center with gum, candy, soda or any type of "junk food". They are not allowed in Day Care.

I have read the above statements and understand and agree to abide by them.

I agree to pay the fee based on the number of hours I will need services for my child / children.

I understand the rest time routine for my child.

I understand that I am responsible for reading and abiding by the procedures in the Parent Handbook.

Child's Name _____ Date _____

Parent / Guardian Signature _____

OCFS-LDSS-4433 (Rev. 06/2019)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

# CHILD IN CARE MEDICAL STATEMENT

## To Be Completed By Licensed Physician, Physician Assistant or Nurse Practitioner

| Name of Child: | Date of Birth: / / | Date of Examination: / / |
|---|---|---|
| | | |

**Immunizations required for entry into day care**

**Medical Exemption** The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s). ☐ Yes ☐ No

| | | | | | |
|---|---|---|---|---|---|
| Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP) | 1st Date / / | 2nd Date / / | 3rd Date / / | 4th Date / / | 5th Date / / |
| Polio (IPV or OPV) | 1st Date / / | 2nd Date / / | 3rd Date / / | 4th Date / / | |
| Haemophilus influenzae type B (Hib) | 1st Date / / | 2nd Date / / | 3rd Date / / | 4th Date **OR** 1st Date (if given on or after 15 months of age) / / | |
| Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08) | 1st Date / / | 2nd Date / / | 3rd Date / / | 4th Date | |
| Hepatitis B | 1st Date / / | 2nd Date / / | 3rd Date / / | | |
| Measles, Mumps and Rubella (MMR) | 1st Date / / | 2nd Date / / | | | |
| Varicella (also known as Chicken Pox) | 1st Date / / | 2nd Date / / | | | |

## Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

| | | | |
|---|---|---|---|
| Type of Immunization: | Date: / / | Type of Immunization: | Date: / / |
| Type of Immunization: | Date: / / | Type of Immunization: | Date: / / |
| Type of Immunization: | Date: / / | Type of Immunization: | Date: / / |

## Tests

Tuberculin Test Date: / / Mantoux Results: ☐ Positive ☐ Negative _____ mm

TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: / /

Attach lead level statement

**Lead Screening (Include All Dates and Results)**

1 year / / Result: _____ mcg/dL ☐ Venous ☐ Capillary

2 years / / Result: _____ mcg/dL ☐ Venous ☐ Capillary

**Most recent date of lead screening (if different from above):**

/ / Result: _____ mcg/dL ☐ Venous ☐ Capillary

**Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely.** If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

*(Continued on reverse side)*

# CHILD IN CARE MEDICAL STATEMENT *(continued)*

| Health Specifics | | Comments |
|---|---|---|
| Are there allergies? (Specify) | ☐ Yes ☐ No | |
| Is medication regularly taken? (Specify drug and condition) | ☐ Yes ☐ No | |
| Is a special diet required? (Specify diet and condition) | ☐ Yes ☐ No | |
| Are there any hearing, visual or dental conditions requiring special attention? | ☐ Yes ☐ No | |
| Are there any medical or developmental conditions requiring special attention? | ☐ Yes ☐ No | |

## Summary of Physical Exam

Include special recommendations to child day care providers

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care. ☐ Yes ☐ No

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

( ) - Phone

/ / Date