

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"/> Speech/Language <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Allergies (Please 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 care 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: / /

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

CHILD IN CARE MEDICAL STATEMENT (continued)

Health Specifics

Comments

Table with 3 columns: Question, Yes/No, and Comments. Rows include: Are there allergies?, Is medication regularly taken?, Is a special diet required?, Are there any hearing, visual or dental conditions..., Are there any medical or developmental conditions...

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