

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

PHOTO OF CHILD REQUIRED	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: <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: ( ) -			ADDRESS OF PERSON ENROLLING CHILD (IF DIFFERENT THAN CHILD):			
EMAIL ADDRESS:			<input type="checkbox"/> ok to text			
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	
<b>FOR PROGRAM USE ONLY</b>			<b>FOR PROGRAM USE ONLY</b>			
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: <a href="https://nystateofhealth.ny.gov/">https://nystateofhealth.ny.gov/</a>		
<b>AGREEMENTS</b>		
<input type="checkbox"/> I consent to emergency medical treatment for my child.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> 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
<input type="checkbox"/> 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
<input type="checkbox"/> 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
<input type="checkbox"/> 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
<input type="checkbox"/> 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: / /