Ann & Andy Child Care Center
Application for Enrollment

Child Information

Child's Name:	
Date of Birth:	**Primary Language:**
Requested Start Date:	**Secondary Language:**

Parent/Guardian Information

Parent / Guardian 1	Parent / Guardian 2
Name:	**Name:**
Home Address:	**Home Address:**
Home/Cell Phone:	**Home/Cell Phone:**
Email Address:	**Email Address:**
Occupation:	**Occupation:**
Work Address:	**Work Address:**
Work Phone:	**Work Phone:**

Sibling Information (if applicable)

Names & Ages:

Health Information

Child's Physician:	**Phone Number:**
Physician Address:	
Allergies:	
Medications Taken Regularly:	
Are there any health, medical, or support needs we should be aware of to best support your child? ☐ No ☐ Yes (please explain):	

Attendance Schedule

	Monday	Tuesday	Wednesday	Thursday	Friday
Scheduled Hours:					

Participating in School Food Program? ☐ Yes ☐ No

Payment Plan: ☐ Weekly ☐ Bi-Weekly (Paid in Advance) ☐ Monthly (Paid in Advance)

How did you hear about Ann & Andy Child Care Center? _____

Office Use Only

Application Date:	**Room:**
Registration /Holding Fee Received: ☐ Yes ☐ No	**Amt Paid:**
Method of Pmt:	**Date of Pmt:**

SCHEDULE AND PAYMENT CONTRACT

CHILD'S NAME_____

Please indicate your child's days and hours below:

HOURS	MON	TUES	WED	THURS	FRI
FULL DAY					
AM HOURS					
PM HOURS					

Payment Plan (Please check your choice):

_____WEEKLY ____BI-WEEKLY IN ADVANCE _____MONTHLY IN ADVANCE

_____AFTER SCHOOL ONLY MONTHLY IN ADVANCE

If payments are not received promptly, a pre-payment schedule will be enforced. All payments are due upon receipt of the bill, UP TO AND INCLUDING DATE OF PAYMENT. There will be a $25.00 charge for any returned check.

I agree to bring my account to a -0- balance by my last scheduled day of December, my last scheduled day of June (before the summer session begins), and my last scheduled day of the summer session. Failure to do so will result in a $25.00 fee per week and require future payments to be made in advance.

I agree to give at least 2 weeks' notice to terminate care or to change my schedule, or I am responsible for the monetary equivalent of the days and hours I have reserved.

I have submitted an **enrollment form and fee**, for a new student, of $125.00 (plus $25.00 for each additional sibling enrolled at the same time, if applicable). There is a holding fee that is equivalent to 2 weeks of care per child which will be applied to your account at the end of the school year or your 2-week notice. I understand that this fee is **NON-REFUNDABLE** should I decide not to send my child(ren) to Ann & Andy.

By signing below, I agree to all the terms and conditions set forth above.

_____ _____

Print Parent's Name Parent's Signature

Date_____

ADDITIONAL OBLIGATIONS

Child's Name_____ Date Signed_____

I acknowledge and agree to the following:

1. I have read and agree to all terms contained in the Things to Know Brochure, including but not limited to the hourly rates.

   Parent Signature_____

2. I agree to reserve a schedule and adhere to that schedule. I also agree to be monetarily responsible for my child's schedule. In addition, I understand the two-week notification clause (which is not applicable to the summer session).

   Parent Signature_____

3. I assume responsibility for the safe transportation of my child to and from the center, as well as bringing my child to their teacher/caregiver.

   Parent Signature_____

3A. (Applicable to the After-School Program)
I give Ann & Andy and their staff permission to transport my child to the center from their school, if applicable.

   Parent Signature_____

4. I agree that in case of accident or injury, emergency care may be given if I, or persons designated, cannot be reached.

   Parent Signature_____

5. I have read and understand the Medicine Administration section.

   Parent Signature_____

6. I give consent for my child to take part in field trips or excursions away from the facility under proper supervision and with prior notification. (If applicable, beginning in Pre-K3)

   Parent Signature_____

7. I give my permission to DCA/Ann and Andy Child Care Center to take pictures of my child(ren) and use them on our website, Facebook page, newsletters, brochures and in our advertising.

   Parent Signature_____

8. (Applicable to Room 4)
I have read and agree to the Continuity of Care section in the Things to Know Packet.

   Parent 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

PERMISSION FORM FOR OVER THE COUNTER
TOPICAL MEDICATION, SUNSCREEN AND INSECT REPELLANT

Date of Permission_____

Permission expiration_____

I _____ the parent of _____

Authorize the day care program to administer the following:

1. **Name of Product:**
   a. Name of product _____
   b. Reason to apply _____
   c. Timing _____
   d. Where to _____
   e. Amount to apply _____
   f. Side effects or adverse reactions _____
   ( ) Parent ( ) Stock

2. **Name of Product:**
   a. Name of product _____
   b. Reason to apply _____
   c. Timing _____
   d. Where to _____
   e. Amount to apply _____
   f. Side effects or adverse reactions _____
   ( ) Paren ( ) Stock

3. **Name of Product:**
   a. Name of product _____
   b. Reason to apply _____
   c. Timing _____
   d. Where to _____
   e. Amount to apply _____
   f. Side effects or adverse reactions _____
   ( ) Parent ( ) Stock

4. **Name of Product:**
   a. Name of product _____
   b. Reason to apply _____
   c. Timing _____
   d. Where to _____
   e. Amount to apply _____
   f. Side effects or adverse reactions _____
   ( ) Parent ( ) Stock

Parent's signature _____ Date _____

My signature below indicates that I have received the listed over-the-counter topical ointments, sunscreens, insect repellants and medications. I have reviewed the parents' instructions and understand them.

Child Care Provider's signature _____ Date _____

CHILD'S PROFILE

Child's Name: _____

Date of Birth: _____

Parent's Names: _____

Parent's Contact Numbers:

Home Phone # _____

Mother's work # _____

Mother's cell # _____

Mother's Email _____

Father's work # _____

Father's cell # _____

Father's Email _____

****

Please list any information you think would assist us in getting to know your child better (i.e., likes, dislikes, allergies, fears, etc.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please return this form on your child's first day of school. Thank you.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD DAY CARE CENTER
SLEEPING AND NAPPING AGREEMENT

This form may be used to meet the regulatory requirement that, other than for school-age children, sleeping and napping arrangements must be made in writing between the parent and the program.

Name of Child in Care:	**Date of Birth** / /

Name of Parent/Guardian:	
Name of Program:	Facility ID#

Area of program where child will nap or sleep:
Napping or sleeping surface (Check all that apply): ☐ Mat ☐ Cot ☐ Bed ☐ Crib
How will the child be supervised?

All applicable regulations must be followed, including, but not limited to, those listed below. Contact your regulator with any questions.

- In a child day care center, children may not sleep or nap in car seats, baby swings, strollers, infant seats, or bouncy seats, unless otherwise prescribed by a health care provider. Should a child fall asleep in one of these devices, they must be moved to an approved sleeping surface.
- Sleeping arrangements for infants through 12 months of age require that the infant be placed flat on their back to sleep, unless medical information from the child's health care provider is presented to the program by the parent that shows that arrangement is inappropriate for that child.
- Cribs, bassinets, and other sleeping areas for infants through 12 months of age must include an appropriately sized fitted sheet and must not have bumper pads, toys, stuffed animals, blankets, pillows, wedges, or infant positioners. Wedges or infant positioners will be permitted with medical documentation from the child's health care provider.
- The resting/napping places must be located in approved day care space; be located in safe areas of the program; be located in a draft-free area; be where children will not be stepped on; be in a location where safe egress is not blocked; allow a person to move freely and safely within the napping area in order to check on or meet the needs of children; and be at least two feet apart from each other.
- Children unable to sleep during nap time shall not be confined to a sleeping surface (cot, crib, etc.) but instead must be offered a supervised place for quiet play.
- A copy of this agreement must be kept on file at the program and accessible for review.

Signature of Parent/Guardian	Signature of Program Staff
/ /	/ /
Date	Date