

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: 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: ( ) - <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
<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: / /
<b>Check boxes below to indicate if your child has any special needs/services:</b> <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 <b>AND</b> 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>	
<ul style="list-style-type: none"> <li>• I consent to emergency medical treatment for my child..... <input type="checkbox"/> Yes   <input type="checkbox"/> No</li> <li>• 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</li> <li>• 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</li> <li>• 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</li> <li>• 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</li> <li>• 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</li> </ul>	
DATE:	