

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

**PHOTO OF  
CHILD (Optional)**

Child's Full Name:		Date of Birth: / /	Gender:
Preferred Name/Nickname:			
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 Email Address:	Address of Person Enrolling Child (if different than child):
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	EMERGENCY CONTACT NAMES / ADDRESSES	Authorized to Pick Up	PRIMARY PHONE NUMBER	OTHER PHONE NUMBER / EMAIL
<b>EMERGENCY INFO</b>	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

<i>For Program Use Only</i> Date of Enrollment:     /     /	<i>For Program Use Only</i> Date of Disenrollment:     /     /
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Child's Full Name:	Date of Birth: / /
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**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 (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 insurance 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: / /
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