**OCFS-LDSS-0792** (08/2019) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

# DAY CARE ENROLLMENT

PHOTO OF CHILD (Optional)

| PROGRAM NAME: | ADDRESS: | PHONE NUMBER: |
|---|---|---|
| Windsor Academy | 271 Quassaick Ave.New Windsor, NY 12553 | (845 )562 - 3711 |

| CHILD'S FULL NAME:<br>PREFERRED NAME/NICKNAME: | DATE OF BIRTH:<br>/ / | GENDER: |
|---|---|---|

CHILD'S HOME ADDRESS:

| NAME OF PERSON ENROLLING CHILD: | RELATIONSHIP TO CHILD:<br>☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative _____<br>☐ Other _____ |
|---|---|

| PHONE NUMBER(S) OF PERSON ENROLLING CHILD:<br>( ) - ☐ ok to text<br>**EMAIL ADDRESS:** | ADDRESS OF PERSON ENROLLING CHILD (IF DIFFERENT THAN CHILD): |
|---|---|

**EMERGENCY INFO**

| EMERGENCY CONTACT NAMES / ADDRESSES | Authorized to Pick Up Child | PRIMARY PHONE NUMBER | OTHER PHONE NUMBER / EMAIL |
|---|---|---|---|
| PRIMARY CONTACT: | ☐ Yes ☐ No | ( ) - ☐ ok to text | ( ) - ☐ ok to text |
| | ☐ Yes ☐ No | ( ) - ☐ ok to text | ( ) - ☐ ok to text |
| | ☐ Yes ☐ No | ( ) - ☐ ok to text | ( ) - ☐ ok to text |

| ***FOR PROGRAM USE ONLY***<br>DATE OF ENROLLMENT: / / | ***FOR PROGRAM USE ONLY***<br>DATE OF DISENROLLMENT: / / |
|---|---|

**OCFS-LDSS-0792** (08/2019) REVERSE

| CHILD'S FULL NAME: | DATE OF BIRTH:<br>/ / |
|---|---|

**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 (Please list) _____

☐ Other _____

Please provide information here **AND** discuss with your child care provider:

| CHILD'S PRIMARY CARE PHYSICIAN'S NAME/ GROUP: | PHONE NUMBER:<br>( ) - |
|---|---|
| PREFERRED HOSPITAL: | PHONE NUMBER:<br>( ) - |
| CHILD'S DENTAL CARE: | PHONE NUMBER:<br>( ) - |

**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

- 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:<br>/ / |
|---|---|