OCFS-LDSS-0792 (1/2005) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DAY CARE REGISTRATION

PHOTO OF CHILD (Optional)

Child's Full Name:

Does your child have any allergies? ☐ Yes ☐ No
If Yes, what is your child allergic to?

Children who have special health care needs are those who have chronic physical, developmental, behavioral or emotional conditions expected to last 12 months or more and who also require health and related services of a type beyond that required by children generally. If your child does have special health care needs please discuss these with your child-care provider.

Child's Source of Medical Care/Primary Care Physician's Name:	Telephone Number:
Child's Source of Dental Care/Dentist's Name:	Telephone Number:
Name Of Medical Care Facility/Hospital:	Telephone Number:

Would you like information on Child Health Plus? ☐ Yes ☐ No

EMERGENCY DATA

RELATIONSHIP	CONTACT NAME	TELEPHONE NUMBER DURING CHILD CARE	OTHER TELEPHONE NUMBER (Check type)
			☐ Pager ☐ Cell ☐ Other
			☐ Pager ☐ Cell ☐ Other
			☐ Pager ☐ Cell ☐ Other
			☐ Pager ☐ Cell ☐ Other

Provider/Day Care Facility Name and Address:

CHILD'S FULL NAME:	SEX: ☐ Male ☐ Female
CHILD'S HOME ADDRESS:	DATE OF BIRTH:
	HOME TELEPHONE NUMBER:

DATE OF ACCEPTANCE:	DATE OF DISCHARGE:

NAME OF PERSON APPLYING FOR CHILD:	☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative ☐ Other ____	HOME TELEPHONE NUMBER:
		DAYTIME TELEPHONE NUMBER:

ADDRESS OF PERSON LISTED ABOVE: (IF DIFFERENT FROM CHILD'S):

AGREEMENTS

I consent to the enrollment of the child listed above in this facility and have been advised of the policies regarding administration of medications, fees, transportation and the services provided by the facility, and the Office of Children and Family Services regulations under which it operates.

I give consent for my child to take part in neighborhood trips (i.e. library, park and playground) away from the facility under proper supervision. ☐ Yes ☐ No

In case of accident or injury, I authorize any and all emergency medical, dental, and /or surgical care and hospitalization advised by the physicians, surgeon or hospital (listed on the other side of this card) necessary for the proper health and well-being of my child. ☐ Yes ☐ No

I have provided information on my child's special needs (Allergies, Diet, Disabilities, and /or Medical Information) to the provider, as may be necessary to assist the facility in properly caring for my child in case of an emergency. ☐ Yes ☐ No

I agree to review and update this information whenever a change occurs and at least once every six months. ☐ Yes ☐ No

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE	DATE:

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly Press Hard

STUDENT ID NUMBER OSIS ☐☐☐☐☐☐☐☐☐

Child's Last Name | First Name | Middle Name | **Sex** ☐ Female ☐ Male | **Date of Birth** *(Month/Day/Year)* __/__/____

Child's Address | **Hispanic/Latino?** ☐ Yes ☐ No | **Race** *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other ______

City/Borough | State | Zip Code | School/Center/Camp Name | District Number ___ | **Phone Numbers** Home ___ Cell ___ Work ___

Health Insurance (including Medicaid)? ☐ Yes ☐ No | ☐ **Parent/Guardian** ☐ **Foster Parent** Last Name | First Name

Birth history *(age 0-6 yrs)*
☐ Uncomplicated ☐ Premature: ______ weeks gestation
☐ Complicated by ______

Allergies ☐ None ☐ Epi pen prescribed
☐ Drugs *(list)* ______
☐ Foods *(list)* ______
☐ Other *(list)* ______

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF/Asthma Action Plan)*: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
If persistent, check all current medication(s): ☐ Inhaled corticosteroid ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ **Other** *(specify)* ______

Explain all checked items above or on addendum

Medications *(attach MAF if in-school medication needed)*
☐ None ☐ Yes *(list below)*

Dietary Restrictions
☐ None ☐ Yes *(list below)*

PHYSICAL EXAMINATION

Height ______ cm (____ %ile)
Weight ______ kg (____ %ile)
BMI ______ kg/m^2 (____ %ile)
Head Circumference *(age ≤2 yrs)* ______ cm (____ %ile)
Blood Pressure *(age ≥3 yrs)* ______ / ______

General Appearance:

Nl	Abnl		Nl	Abnl		Nl	Abnl		Nl	Abnl		Nl	Abnl	
☐	☐	HEENT	☐	☐	Lymph nodes	☐	☐	Abdomen	☐	☐	Skin	☐	☐	Psychosocial Development
☐	☐	Dental	☐	☐	Lungs	☐	☐	Genitourinary	☐	☐	Neurological	☐	☐	Language
☐	☐	Neck	☐	☐	Cardiovascular	☐	☐	Extremities	☐	☐	Back/spine	☐	☐	Behavioral

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)* ☐ Within normal limits
☐ Delay suspected, specify below
☐ Cognitive *(e.g., play skills)* ______
☐ Communication/Language ______
☐ Social/Emotional ______
☐ Adaptive/Self-Help ______
☐ Motor ______

SCREENING TESTS	Date Done	Results
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	__/__/__ __/__/__	____ µg/dL ____ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	__/__/__	☐ At risk *(do BLL)* ☐ Not at risk
Hearing ☐ Pure tone audiometry ☐ OAE	__/__/__	☐ Normal ☐ Abnormal
— Head Start Only —		
Hemoglobin or Hematocrit *(age 9–12 mo)*	__/__/__	____ g/dL ____ %

	Date Done	Results
Tuberculosis *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school*		
PPD/Mantoux *placed*	__/__/__	Induration ____ mm
PPD/Mantoux *read*	__/__/__	☐ Neg ☐ Pos
Interferon Test	__/__/__	☐ Neg ☐ Pos
Chest x-ray *(if PPD or Interferon positive)*	__/__/__	☐ Nl ☐ Abnl ☐ Not Indicated
Vision *(required for new school entrants and children age 4–7 yrs)*	__/__/__ ☐ with glasses	Acuity Right __/__ Left __/__ Strabismus ☐ No ☐ Yes

IMMUNIZATIONS – DATES CIR Number of Child ☐☐☐☐☐☐☐☐☐

Vaccine				
Hep B	__/__/__	__/__/__	__/__/__	__/__/__
Rotavirus		__/__/__	__/__/__	__/__/__
DTP/DTaP/DT		__/__/__	__/__/__	__/__/__
		__/__/__	__/__/__	__/__/__
Hib	__/__/__	__/__/__	__/__/__	__/__/__
PCV	__/__/__	__/__/__	__/__/__	__/__/__
Polio	__/__/__	__/__/__	__/__/__	__/__/__

Vaccine			
Influenza	__/__/__	__/__/__	__/__/__
MMR	__/__/__	__/__/__	__/__/__
Varicella	__/__/__	__/__/__	
Td	__/__/__	__/__/__	__/__/__
Tdap __/__/__	Hep A	__/__/__	__/__/__
Meningococcal	__/__/__	__/__/__	
HPV	__/__/__	__/__/__	__/__/__
Other, *specify:* ______	__/__/__	______	__/__/__

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet
☐ Restrictions *(specify)* ______
Follow-up Needed ☐ No ☐ Yes, for ______ Appt. date: __/__/__
Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision
☐ Other ______

ASSESSMENT ☐ Well Child (V20.2) ☐ Diagnoses/Problems *(list)* **ICD-9 Code**

Health Care Provider Signature | Date __/__/__ | **DOHMH ONLY** **PROVIDER I.D.** ☐☐☐☐☐☐

Health Care Provider Name and Degree *(print)* | Provider License No. and State | **TYPE OF EXAM:** ☐ NAE Current ☐ NAE Prior Year(s)

Facility Name | National Provider Identifier (NPI) | *Comments*

Address | City | State | Zip | Date Reviewed: __/__/__ | I.D. NUMBER ☐☐☐☐☐☐☐

Telephone ( ) | Fax ( ) | REVIEWER:

CH-205 (5/08)

Copies. White School/Child Care/Early Intervention/Camp. Canary Health Care Provider. Pink Parent/Guardian

318K (REV. 4/12)

CENTER
NAME:
ADDRESS:
BORO:

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BUREAU OF CHILD CARE

DAY CARE CUMULATIVE HEALTH RECORD

TO BE COMPLETED BY PARENTS/GUARDIANS AND DAY CARE STAFF

Date of Admission ____/____/____

NAME: (Last) (First) (Middle)	SEX F ❑ M ❑	DATE OF BIRTH Country/State of Birth
ADDRESS: (No.) (Street) (City/Boro) (State) (Zip)		
MOTHER'S NAME: (First) (Last) FATHER'S NAME: (First) (Last)		TELEPHONE NO Home: Work:
FOSTER PARENT		
FOSTER AGENCY	ADDRESS	TELEPHONE #
LANGUAGE SPOKEN IN HOME		

PERSON/S TO CONTACT IN CASE OF EMERGENCY *(Other Than Parent)*	
NAME	RELATIONSHIP TO CHILD
ADDRESS	TELEPHONE NO. Home: Work:

NAME OF MEDICAL PROVIDER, CLINIC OR HOSPITAL

NAME	CONTACT PERSON	PATIENT NO.
ADDRESS		TELEPHONE NO.

SIGNIFICANT FAMILY HISTORY		IS CHILD ALLERGIC TO ANY:
(____) Asthma	(____) Heart Disease	(____) Medications *(Specify)*
(____) Diabetes	(____) Hypertension	(____) None ____
(____) Convulsive Disorder	(____) Tuberculosis	(____) Foods *(Specify)* ____
(____) Allergies *(Specify)*	(____) Vision	(____) Insect Bites ____
(____) OTHER *(Specify)*	(____) Hearing	(____) OTHER ____

HOSPITALIZATIONS AND ILLNESSES	YES	NO	EXPLAIN
Has child ever been hospitalized or operated on?			
Has child ever had a serious accident (broken bone, head injury, fall, burns, poisoning)?			
Has child ever had a serious illness?			

SPECIAL HEALTH CONDITIONS (Long term or chronic)	AGE IT BEGAN	TREATMENT/MEDICATIONS
1. ____		
2. ____		
3. ____		
4. ____		
5.		

I, ______________________ hereby certify that information provided herein is complete and accurate.

CONSENT FOR EMERGENCY MEDICAL TREATMENT *(REQUIRED FOR ADMISSION TO DAY CARE)*

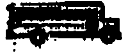
I do hereby give authority to the day care program staff to obtain necessary emergency medical treatment for my child, with the understanding that the family will be notified as soon as possible.

SIGNED ______________ DATE ______________ RELATIONSHIP ______________

Subscribed and sworn to before me this ____ day of ________ 19 ____

______________________ ______________________

Notary Public or Commissioner of Deeds (OPTIONAL) County of



PICK UP AUTHORIZATION

I (we) the parent(s) of ______________________________, give my (our) consent for the following individual(s) to pick up my (our) child if I (we) are unable to do so.

Name	Address	Phone #

The following individual(s) are not allowed to pick up my (our) child.

1. ______________________________
2. ______________________________

______________________________ ______________________________

Parent(s) signature **Date**

______________________________ ______________________________

Provider signature **Date**

Transportation Agreement

I give ______________________ my
(PROVIDERS' NAME, DRIVERS' NAME)

permission to transport my child
_______________ by _______, to and
(CHILDS' NAME) (VAN, CAR, BUS)

from school, home etc.

____

Parent signature

____

Date

____

Providers' signature

____

Date

Feeding Schedule

FOR ______________________, DOB: ______________________,
(Child's Name)

I ______________________
(Parent's Name)

☐ Will Supply ______________________, with _____ bottles of prepared
(Provider's Name)

______________________ formula, to be fed _____ tir
(Name of Formula)

☐ Give permission to the On-Site Provider to prepare ______________________
(Name of Formula)

formula, for _____ bottles per day, to be fed _____ times a day.

☐ Will also provide:

_____ Bottle/s of water, to be fed _____ times a day,
_____ Bottle/s of juice, to be fed _____ times a day,
_____ Yogurt, to be fed _____ times a day,
_____ Puree fruit, to be fed _____ times a day,
_____ Cereal, to be fed _____ times a day by spoon.

Additional Notes:

____
____
____
____
____

Parent's Signature:

Signature: ______________________ Date: ______________

SLEEPING AND NAPPING ARRANGEMENT
Family Day Care and Group Family Day Care

Sleeping and napping arrangements must be made in writing between the parent and the child care provider. The provider shall maintain this completed agreement on file in the child care home. This arrangement is required by New York State Child Day Care Regulations [Family Day Care 417.7(l) and 417.8(a)(1), and Group Family Day Care 416.7(l) and 416.8(a)(1)].

I, ______________________ (parent name), understand that my child, ______________________ (child name),

while under the care of ______________________ (child care provider or program name), will be napping on a

______________ (cot, mat, bed or crib) in the ______________________ (area of home) of the child care home.

My napping child will have competent supervision at all times, either through:

(Check one box:)

- ☐ **direct supervision by a caregiver who is in the same room and has direct visual contact with him/ her;**

OR

- ☐ **indirect supervision by a caregiver who uses a functioning electronic monitor and remains on the same floor as my child at all times. The doors to all rooms where children are napping must remain open, as well as the doors to all rooms used by the provider.**

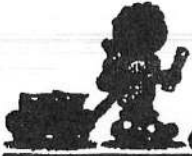
If my child is an infant, I also understand that my child will be placed on his/ her back to sleep.

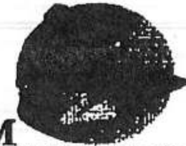
Parent Signature: ______________________

Date (Month/ Day/ Year): ______________________

Child Care Provider Signature: ______________________

Date (Month/ Day/ Year): ______________________





OUT DOOR ACTIVITY PERMISSION FORM

The provider and staff

of________________________________ may take my

child ________________________for short walking

trips and any of the activities checked below as

part of the Family/Group Family Day Care

Program.

( ) Providers' back yard

( ) Neighborhood Park

( ) Other ______________________________

Parent/Guardian (print)

______________________**Date__/__/__**

Photo Consent Form

By signing this form, I _______________________ (Parent/Guardian's name) give my complete consent and authorization for Pear Tree Explorers Home Child Care, Inc.'s staff members to take photographs of my child. I also give permission to send photos through portable mobile devices (i.e. cell phones, laptops, tablet, etc.) I also give permission to Pear Tree Explorers Home Child Care, Inc. to print and/ or publish the photos that include my child in school newsletters, bulletin boards, online marketing portals (including PearTreeExplorers.com, Pear Tree Explorers Facebook Page, Pear Tree Explorers Instagram Page, and Pear Tree Explorers Yelp Page) and in classroom arts and crafts projects.

My child(ren)'s name: ___________________________.

____
Parent/Guardian's Signature

____
Parent/Guardian's Name Printed

Date:___________________________

WEEKLY CHILD CARE SCHEDULE

1. **MONDAY** DROP OFF TIME:___________
   PICK UP TIME:_____________
   TOTAL HOURS:________________________

2. **TUESDAY** DROP OFF TIME:___________
   PICK UP TIME:_____________
   TOTAL HOURS:________________________

3. **WEDNESDAY** DROP OFF TIME:___________
   PICK UP TIME:_____________
   TOTAL HOURS:________________________

4. **THURSDAY** DROP OFF TIME:___________
   PICK UP TIME:_____________
   TOTAL HOURS:________________________

5. **FRIDAY** DROP OFF TIME:___________
   PICK UP TIME:_____________
   TOTAL HOURS:________________________

TOTAL WEEKLY HOURS OF CHILD CARE:________________

Emergency Contact

In case of an emergency please use the following information listed below to contact the parents, family members or close friends of my children or child ________________________.

Mothers Name:______________________

Job: ________________

Cell:________________

Home: ______________

Fathers Name: ______________________

Job: ___________________

Cell: __________________

Home:_________________

Doctor's name: ______________________

Doctor's number: ____________________

Contact (1) Name: ______________________

Contact (2) Name: ______________________

Contact (3) Name: ______________________