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.

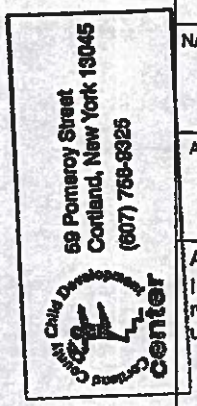
Child's Source of Medical Care/Primary Care Physician's Name:	Telephone Number:
Child's Source of Dental Care/Dentist's Name:	Telephone Number:
Name Of Medical Care Facility/Hospital:	Telephone Number:

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:

OCFS-LDSS-0792 (1/2005) REVERSE

Cortland County Child Development Centers

59 Pomeroy Street • Cortland, New York 13045
(607) 758-9325 • Fax (607) 756-2530
School Age Program (607) 753-6717
Email: childdevschoolage@gmail.com

SCHOOL-AGE ENROLLMENT PROVISIONS

Dear Families:

Welcome to Virgil School-Age Care! We are excited to have your child(ren) on board. The school-age program is held in the Kid's Cafeteria at Virgil Elementary School. **The school-age program opens at 6:45 am and closes promptly at 5:45 pm**. To ensure your child(ren)'s placement, please complete the following paperwork and return it to the Child Development Center with a non-refundable check for 1 full week's tuition.

_____

Child(ren)'s Name; Grade; and Teacher's Name for the **2018-2019** School Year

Please check the appropriate lines:

_____ My child(ren) will attend the program **before school** on:

M T W R F (Circle the days your child will attend)

_____ My child(ren) will attend the program **after school** on:.

M T W R F (Circle the days your child will attend)

_____ My child(ren)_____ will play the following sport(s)_____

For the following dates: _____till_____ and will only need after school care on:

M T W R F (Circle the days your child will attend)

_____ My child(ren) will attend on full day vacation & holiday care

_____ My child(ren) will attend when care is available on snow days.

If the program must close due to unforeseen circumstances please contact _____ at:

_____. Call; Text; E-mail (Circle one)

Services & Fees

- Tuition will be charged based on your **requested schedule** of enrollment, regardless of actual attendance.
- Scholarships are need based and will be considered on an individual basis if children are attending Monday-Friday. (To be considered) Please submit proof of household income.
- Since our Center closes promptly at 5:45, a $1.00 a minute late fee will be charged past this time to the remaining staff person.
- For children attending 5 days a week, the eldest child will be full price, all other children will receive a 20% discount.
- The child must attend a minimum of two days per week.
- Please submit notice in writing two weeks before withdrawing your child(ren) from the program.

Services for children	Tuition (Per Child)
Before & after school care	$75 per week ($15/day)
Before school care *only*	$40 per week ($8/day)
After school care *only*	$60 per week ($12/day)
Full day care per week	$170 per week
Single full day care	$37 single day

Based on your requested schedule, please fill in your projected weekly tuition:

$_____ and attach payment for your 1st scheduled week.

Please plan on paying your tuition at the beginning of each week. The checks (make out to CDC) or cash should be put in envelopes and placed in the black box on the wall. You will always receive a receipt from the main office.

Meals

Meals will be provided by the Child Development Center when your child attends during scheduled meal times. The menu will be developed in accordance with the nutritional guidelines of the Child and Adult Feeding Program of the NYS Health Department.

I agree with the above provisions

_____ **Signature**

Date

Thank you for placing your youngster(s) in our program. We appreciate the opportunity to be of service to your family and encourage on-going communication with the center's staff. Together we will provide a safe, creative, and productive recreational program.

Courtney Peters
School-Age Coordinator

Heidi Hill
Assistant School-Age Coordinator

Jennifer Robinson
Executive Director

United Way

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Liability Agreement

I agree that **my child will be responsible for his/her own personal belongings.** I will not hold the program or its employees responsible for lost or damaged items.

On field trips some destinations may have vending machines, souvenirs and/or arcade games. We ask that the children **please keep any personal money at home.** If any money is brought it the program will not be responsible to any money that is lost.

By signing below you agree to our stated liability agreement

_____

Signature Date

Permission Form

Please initial each one and sign the bottom:

___ I give permission for the Child Development Program to take my child(ren) on walking trips throughout the neighborhood. Trips by school, city or private bus transportation will be preceded by a permission form, which will detail destination and supervision

___ I give permission for staff to transport my child by car if necessary

___ I give permission for the staff to obtain any emergency medical/surgical treatment and/or transportation by ambulance as deemed necessary. The staff will reach me in a timely matter.

___ I give my permission to have my child photographed for possible use in brochures, newspapers, etc.

Parent Signature: _____ Date: _____

Request for Scholarship Assistance

Child Development is very fortunate to have scholarship monies to help reduce weekly tuition. This Scholarship Fund is supported by your donations to our local United Way and parent fundraising events.

If you would like to be considered for scholarship monies please submit proof of income for all the working members of your household. This could be current pay stubs, copies of your income tax or a statement from the employer. Also indicate the number of people in your household.

♦♦

Your Name: ______________________________

Your Child(ren)'s Name: ______________________________

The number of people in your household: __________

Current gross household income (before taxes are taken out)

$ ___________ **(please attach documentation)**

Any family that receives a scholarship will be requested to assist with center fundraisers to help replenish the fund for future use. Thanks for your information. I'll review and return to you with your adjusted tuition.

♦♦♦

For Office Use Only

Present tuition__________Scholarship__________New tuition____________

CONTACT INFORMATION

Parent/Guardian Schedule

Parent/Guardian's Name _____

Parent/Guardian place of employment _____

Hours of employment _____

Work # _____ Cell # _____

Parent/Guardian's Name _____

Parent/Guardian place of employment _____

Hours of employment _____

Work # _____ Cell # _____

Person(s) to be contacted in Case of Emergency

Please list whomever you would like to be contacted first in case of an unplanned closing of the program. Please be sure to include someone who lives or works locally and will usually know your whereabouts. Not going to be in town for the day? Please let a staff person know.

**Name_____ Daytime Phone #_____

Name_____ Daytime Phone #_____

Name _____ Daytime Phone #_____

Name_____ Daytime Phone #_____

Name_____ Daytime Phone #_____

Physician's Name_____ Phone #_____

Persons Authorized to Pick Up Your Child

Under no circumstances will a child be released to anyone not authorized by the parent or guardian. The child(ren) will be released to either parent unless a court order is on file restricting custody and/or visitation.

Name_____ Address_____

Daytime Phone #_____ Relationship to Child _____

Name_____ Address_____

Daytime Phone # _____ Relationship to Child _____

Name _____ Address _____

Daytime Phone # _____ Relationship to Child _____

Name_____ Address_____

Daytime Phone #_____ Relationship to Child _____

Name_____ Address_____

Daytime Phone # _____ Relationship to Child _____

Name _____ Address _____

Daytime Phone # _____ Relationship to Child _____

_____ Please check here if you prefer that no one else pick up your child except the child's parents/guardians.

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Authorization for Topical Treatment

Child's Name: _____ Date of Birth: _____

I authorize my child's daycare provider to administer the over-the-counter topical treatments selected below (any brand unless noted), as needed. **I understand that the staff will use the brand that I have provided unless the classroom has a stocked item, like sunscreen.**

____ Sunscreen lotion

____ Aloe Vera

____Vaseline

____ Hydrocortisone

____ Antibiotic Ointment

____ Peroxide

____ Bactine

____ Child's insect repellant

____ Insect Sting Medicine

____ Other: _____

Comments:

_____

_____

_____

Parent/Guardian Signature: _____ Date: _____

Child Name _____

Important Information About Your Child

Please complete the following. This will give us important information regarding your child(ren)'s well-being.

My child has the following medical conditions and accompanying treatment:

_____

My child is allergic to: (ie: bee stings, strawberries)

_____

Here is how I would like my child(ren) cared for if in contact with the above:

_____

If your child has a classroom aide during the school year please indicate what assistance is provided to your child:

_____

Parent's signature and date: _____

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Social Media Release

Child's Name: _____

Please initial one and sign the bottom

____ I give permission for my child's photo to be posted on the School Age's Facebook page. We will not use their name in any way

____ I DO NOT give permission for my child's picture to be posted on the School Age's Facebook page.

Parent/Guardian Signature _____ Date: _____

United Way

Discipline Agreement

The Child Development Center's School-Age Program strives to develop respectful, caring children who have a sense of responsibility to themselves and the individuals around them. This agreement helps set the guidelines that endorse positive behaviors.

Please read and discuss this agreement with your child before you both sign. This agreement will also be reviewed with their group leaders during the first week of camp.

1. I agree to not hit, punch, kick, push, wrestle or put my hands on anyone in an aggressive or mean way.
2. I agree that if I am angry or upset about the way someone behaves towards me that I will find an adult to talk to about it.
3. I agree that words can hurt people and that I will not use bad language or say mean things.
4. I agree that everyone is different and may do things differently than me. I will not make fun of other people or the way they do things.
5. I agree that I must pick up after staff members and follow their directions.
6. I agree to listen to adult staff members and follow their directions.
7. I agree not to take or touch anything that does not belong to me.

***I understand that if I do not follow these guidelines that following will happen:

First offense: Verbal warning

Second offense: Written warning, and written apology letter by child

Third offense: One day suspension from program

Parent Signature:_____

Child's Signature:_____

Group Leader's Signature:_____

AUTHORIZATION FOR MINOR'S MEDICAL TREATMENT

Name of Minor: _____ **Date of Birth:** _____ **Age:** _____

Address: _____ **Phone:** _____

Medical Insurer/Health Plan: _____ **Policy#:** _____

Allergies **Medications** **Last Tetanus Shot**

_____

_____

Note any other significant medical information:

_____

Family Physician or Choice of Specialist: _____

Name & Signature of Parent/Guardian: _____

Address: _____

Phone: _____ **Work Phone:** _____

Name & Signature of Parent/Guardian: _____ _____

Address: _____

Phone: _____ **Work Phone:** _____

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I grant my authorization and consent for Staff or the Cortland Child Development Program to administer general first aid treatment for any minor injuries or illnesses experienced by the minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize the Staff of the Cortland Child Development Program to summon any and all professional emergency personnel to attend, transport, and treat the participant and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the Staff of the Cortland Child Development Program in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

This authorization is effective commencing on the _____ day of _____ 20___ and expiring on the _____ day of _____, 20___. Witnessed & Date: _____

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New Financial Policy Requirements

Our legal advisor has recommended we ask for a copy of your current State ID/drivers license number or your social security number for verification of records. We understand how important it is to keep this information private; therefore the handling of this information will be done only by supervisors, and will be kept in a locked drawer at the Cortland Child Development Center. At the end of the program when the bill has been paid in full you may ask for this form back, or we will destroy it for you. Thank you.

Parent/Guardian Name: _____

State ID/Drivers License Number: _____/_____

State Number

Social Security Number: _____

Please initial next to desired choice:

At the end of the program when my bill is paid in full I would like this form handed back to me._____

At the end of the program when my bill is paid in full I would like this form destroyed._____

Please Complete with signature.
All information remains confidential.

CACFP
Child and Adult Care Food Program
New York State Department of Health

INCOME ELIGIBILITY FORM
for Child Care Centers

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME: _____

Print the name of the child(ren) enrolled in this child care center:

1. _____ 2. _____ 3. _____

DIRECTIONS:

Complete SECTION A if anyone in your household:

1. Receives Food Stamps
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR) OR
4. If any of the children enrolled in this child care center are foster children

Complete SECTION B if no one in your household receives Food Stamps, TANF, FDPIR or if none of the children enrolled in the child care center is a foster child.

SECTION A

Food Stamp Case Number _____

TANF Number _____

FDPIR Number _____

Names of Foster Children _____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true. I understand that the center will get Federal funds based on the information I give.

Signature: _____

Date: _____

FOR SPONSOR USE ONLY

Sponsor Agreement Number _____

Total Household Members _____
(including foster children, if applicable)

Total Income $_____

Free _____ Reduced _____ Paid _____

Date Determined ____/____/____

Signature of Center Staff _____

SECTION B

List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received **last month** in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, child support, foster child's personal income and any other sources of income.

Name of Household Members	Monthly Gross Income
1. _____	$ _____
2. _____	$ _____
3. _____	$ _____
4. _____	$ _____
5. _____	$ _____
6. _____	$ _____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true and that all income is reported. I understand that the center will get Federal funds based on the information I give.

Signature: _____

Print Name: _____

SS# XXX-XX-____ Date: _____

* Must be Signed