## OCFS-LDSS-0792 (08/2019) FRONT **NEW YORK STATE** OFFICE OF CHILDREN AND FAMILY SERVICES DAY CARE ENROLLMENT ADDRESS: PROGRAM NAME: PHONE NUMBER: DATE OF BIRTH: GENDER: CHILD'S FULL NAME: PHOTO OF PREFERRED NAME/NICKNAME: **CHILD** (Optional) CHILD'S HOME ADDRESS: NAME OF PERSON ENROLLING CHILD: RELATIONSHIP TO CHILD: ☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative ☐ Other PHONE NUMBER(S) OF PERSON ENROLLING CHILD: ADDRESS OF PERSON ENROLLING CHILD (IF DIFFERENT THAN CHILD): □ ok to text ) EMAIL ADDRESS: Authorized to **EMERGENCY CONTACT NAMES / ADDRESSES** OTHER PHONE NUMBER / EMAIL PRIMARY PHONE NUMBER Pick Up Child PRIMARY CONTACT: ☐ Yes ☐ No INFO ☐ ok to text ☐ ok to text **EMERGENCY** ) ) ☐ Yes ☐ No ☐ ok to text ☐ ok to text ) ) ☐ Yes ☐ No ok to text ☐ ok to text FOR PROGRAM USE ONLY FOR PROGRAM USE ONLY DATE OF DISENROLLMENT: DATE OF ENROLLMENT: OCFS-LDSS-0792 (08/2019) REVERSE CHILD'S FULL NAME: DATE OF BIRTH: 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: ) 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: https://nystateofhealth.ny.gov/ **AGREEMENTS** • I consent for my child to take part in neighborhood trips (i.e., library, park and playground) away from the program • I understand the program may need additional permissions for situations such as transportation, medication, • I understand the program must give parents, at the time of enrollment of a child, a written policy statement as

DATE:

SIGNATURE - PARENT OR PERSON(S) LEGALLY RESPONSIBLE: