OCFS-LDSS-0792 (10/2018)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DAY CARE ENROLLMENT

PHOTO OF CHILD (Optional)	Child's Full Name: Preferred Name/Nickname:	Date of Birth: / /	Gender:
	Child's Home Address:		
	Name of Person Enrolling Child:	Relationship to Child: ☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative _____ ☐ Other _____	
	Phone Number(s) of Person Enrolling Child: ( ) - ☐ ok to text **Email Address:**	Address of Person Enrolling Child (if different than child):	

EMERGENCY INFO	EMERGENCY CONTACT NAMES / ADDRESSES	Authorized to Pick Up	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	*For Program Use Only*
Date of Enrollment: / /	Date of Disenrollment: / /

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 (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: / /

(Over)

Additional Good Shepherd Emergency Information

Child's Health Insurance	Plan Name:
Plan ID#:	Subscriber's Name (on card):

Transport Arrangement in an Emergency Situation

The nearest available ambulance service will take child to appropriate facility for his/her needs. Parent/guardian will be notified immediately. (Parents/guardians are responsible for all emergency transportation charges.)

Consent for Emergencies	
• I give consent to have my child receive first aid by facility staff and, if necessary, be transported to receive emergency care. I understand that I will be responsible for all charges not covered by insurance. I give consent for the emergency contact person listed over to act on my behalf until I am available.	
SIGNATURE-PARENT/GUARDIAN:	DATE: / /