

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**DAY CARE ENROLLMENT**

PHOTO OF CHILD (Optional)	PROGRAM NAME: <b>Parker Academy CCLC</b>		ADDRESS: <b>49 Indian Church Road, Buffalo, NY, 14210</b>		PHONE NUMBER: <b>(716) 821 - 7704</b>
	CHILD'S FULL NAME:			DATE OF BIRTH:	GENDER:
	PREFERRED NAME/NICKNAME:			/ /	
	CHILD'S HOME ADDRESS:				
NAME OF PERSON ENROLLING CHILD:			RELATIONSHIP TO CHILD:		
			<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Caretaker <input type="checkbox"/> Relative _____ <input type="checkbox"/> Other _____		
PHONE NUMBER(S) OF PERSON ENROLLING CHILD: (   ) -			ADDRESS OF PERSON ENROLLING CHILD (IF DIFFERENT THAN CHILD):		
EMAIL ADDRESS:			School/ Grade:		
EMERGENCY INFO	EMERGENCY CONTACT NAMES / ADDRESSES		Authorized to Pick Up Child	PRIMARY PHONE NUMBER	OTHER PHONE NUMBER / EMAIL
	PRIMARY CONTACT:		<input type="checkbox"/> Yes <input type="checkbox"/> No	(   ) - <input type="checkbox"/> ok to text	(   ) - <input type="checkbox"/> ok to text
			<input type="checkbox"/> Yes <input type="checkbox"/> No	(   ) - <input type="checkbox"/> ok to text	(   ) - <input type="checkbox"/> ok to text
			<input type="checkbox"/> Yes <input type="checkbox"/> No	(   ) - <input type="checkbox"/> ok to text	(   ) - <input type="checkbox"/> ok to text
FOR PROGRAM USE ONLY DATE OF ENROLLMENT:   /   /			FOR PROGRAM USE ONLY DATE OF DISENROLLMENT:   /   /		

CHILD'S FULL NAME:		DATE OF BIRTH: / /
<b>Check boxes below to indicate if your child has any special needs/services:</b> <input type="checkbox"/> None		
<input type="checkbox"/> Early Intervention/Special Education <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech/Language <input type="checkbox"/> Physical Therapy		
<input type="checkbox"/> Allergies (Please list) _____ <input type="checkbox"/> Other _____		
Please provide information here <b>AND</b> 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: (   ) -
<b>Child health care information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: <a href="https://nystateofhealth.ny.gov/">https://nystateofhealth.ny.gov/</a></b>		
<b>AGREEMENTS</b>		
• I consent to emergency medical treatment for my child.....		<input type="checkbox"/> Yes <input type="checkbox"/> 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.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
• I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
• I provided information on my child's special needs to the program to assist in caring for my child.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
• I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
• I agree to review and update this information whenever a change occurs and at least once every year.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:		DATE: / /

### Dismissal

- ( ) My student is a walker and will be dismissed to walk home at the end of the program.
- ( ) I will pick my student up DAILY by or before closing. I understand that a late pick-up fee of \$1 per minute will be charged ten minutes after closing. I also understand that multiple late pick-ups may result in my child's termination.

The following people are authorized to pick up this student:

\*Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

\*Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

\*Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

\*This person must provide a valid photo ID to the staff member on duty before the student will be released.

The following people **ARE NOT** allowed to pick up this student:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

### Insurance Information

Name of insured \_\_\_\_\_

Relationship to child \_\_\_\_\_

Policy ID # \_\_\_\_\_ Group # \_\_\_\_\_

Carrier Address \_\_\_\_\_

### **Any Helpful Information About Your Child:**

### Sunscreen Permission

Please choose **one** of the options below regarding the use of sunscreen on your child.

- ☐ **I give Parker Academy permission** to use sunscreen lotion or spray on my child during field outings if conditions warrant it.
- ☐ I want my child to use sunscreen lotion/spray **that I supply** during field outings should conditions warrant its use. (The lotion/spray must accompany the permission slip, with the child's name clearly labeled on the bottle.)
- ☐ **I DO NOT** permit Parker Academy to use sunscreen lotion/spray on my child. I understand that my child will be susceptible to sunburn during field outings.

### Mosquito Repellent Permission

Please choose **one** of the options below regarding the use of mosquito repellent on your child.

- ☐ **I give Parker Academy permission** to spray my child with mosquito spray during field outings if conditions warrant it.
- ☐ I want my child to use mosquito spray **that I supply** during field outings should conditions warrant its use. (The Spray must accompany the permission slip, and the child's name must be clearly labeled on the bottle.)
- ☐ **I DO NOT** permit Parker Academy to use mosquito spray on my child. I understand my child will be susceptible to insect bites during field outings.

### Media Release

Please choose **one** of the options below regarding the use of external media of your child.

- ☐ **I give Parker Academy permission** to have my child appear in any media coverage approved by Parker Academy Child Care and Learning Center INC.
- ☐ **I DO NOT** permit my child to appear in any media coverage approved by Parker Academy Child Care and Learning Center INC.

Guardian Printed Name: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_