LITTLE SPANISH GARDEN LLC - LSGKIDS

Enrollment Information

Child's Information

Name: _____ Middle: _____ Last: _____ Nickname: _____

Age: _____ Sex: _____ Primary Language: _____ Parent Language: _____

Address: _____ City: _____ State: _____ Zip Code: _____

DOB: _____ Phone: _____ Previous Daycare: _____ Classroom: _____

Mail Address: _____ City: _____ State: _____ Zip Code: _____

Family Information

List family members & pets your child lives with – include first names, relation and ages of siblings _____

_____

Parent/guardian/sponsor: _____ Relationship to child: _____

Home phone: _____ Cell phone: _____ Home email: _____

Work phone: _____ Work email: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Employer: _____ Work hours: _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

Other Parent/guardian/sponsor: _____ Relationship to child: _____

Home phone: _____ Cell phone: _____ Home email: _____

Work phone: _____ Work email: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Employer: _____ Work hours: _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

Child Emergency Contact and Release Information (Do not include parents/guardians/sponsors)

Please notify the center if an Emergency Release Contact will pick up your child on a given day. [For the safety of your child, we request that all authorized pick up persons with whom staff is not familiar provide & photo ID at the time of pick up.]

Person # 1: _____ Relationship to child: _____ Home phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home email: _____ Work email: _____

Work phone: _____ Cell phone: _____ Employer: _____

Employer address: _____ City: _____

State: _____ Zip Code: _____ Work hours: _____

Person # 2: _____ Relationship to child: _____ Home phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home email: _____ Work email: _____

Work phone: _____ Cell phone: _____ Employer: _____

Employer address: _____ City: _____

State: _____ Zip Code: _____ Work hours: _____

Person # 3: _____ Relationship to child: _____ Home phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home email: _____ Work email: _____

Work phone: _____ Cell phone: _____ Employer: _____

Employer address: _____ City: _____

State: _____ Zip Code: _____ Work hours: _____

LITTLE SPANISH GARDEN LLC - LSGKIDS

Completion of this agreement is required for enrollment. This form will enable us to better understand your child and meet his/her needs. Much of the information requested is necessary to comply with state child care licensing regulations.

The persons designated in this section will be contacted by us if you cannot be reached in the event of a medical or other emergency. Our staff will only release your child to you or to those persons listed above. If you want a person who is not identified above to pick up your child, you must notify our staff in advance, in writing. Your child will not be released without prior authorization.

Parent initial _____ Staff initial _____ Date _____

Medical Information

Child's Name: _____ Birth Date: _____

Height: _____ Weight: _____ Hair color: _____ Eye Color: _____

Child's Medical & Developmental History

1. Does your child have any special medical conditions? ◯ Yes ◯ No
   Explain: _____
2. Does your child have any chronic illnesses? ◯ Yes ◯ No
   Explain: _____
3. Please list a brief history of your child's serious injuries and hospitalizations.
4. Does your child have diabetes? ◯ Yes ◯ No
   If yes, please attach care instructions from your physician.
5. Does your child have asthma? ◯ Yes ◯ No
   If yes, please attach care instructions from your physician.
6. Will medication be administered regularly? ◯ Yes ◯ No
   If yes, please attach care instructions from your physician.
7. Does your child have any special dietary needs? ◯ Yes ◯ No
   Explain: _____
8. Is your child able to fully participate in all activities? ◯ Yes ◯ No
   Explain: _____
9. Does your child have any physical restrictions? ◯ Yes ◯ No
   Explain: _____
10. Does your child function at the level of other children in his/her age group? ◯ Yes ◯ No
    Explain: _____

Child's Medical & Developmental History (Cont'd)

11. Can your child communicate his/her needs? ◯ Yes ◯ No
    Explain: _____
12. Does your child need assistance at meal time? ◯ Yes ◯ No
    Explain: _____
13. Does your child rest during the day? ◯ Yes ◯ No
14. Is your child toilet trained? ◯ Yes ◯ No
15. Does your child use any special equipment, such as breathing machine, wheelchair, hearing aid, braces, glasses etc.? ◯ Yes ◯ No
    Explain: _____
16. Does your child require one-to-one care/supervision on a regular basis for a significant period of time? ◯ Yes ◯ No
    Explain: _____
17. Does your child require any accommodations or modifications to fully and equally enjoy and participate in a group care setting? ◯ Yes ◯ No
    Explain: _____

Illness History (please check all that apply)

☐ Vision problems	☐ Nosebleeds	☐ Seizures	☐ Hearing problems
☐ Skin rashes	☐ Mouth sores	☐ Constipation	☐ Sore throats
☐ Fainting	☐ Diarrhea	☐ Ear infections	☐ Persistent cough
☐ Asthma/breathing problems	☐ Urinary tract infections	☐ Other: _____	

Please attach care instructions from your physician for any of these illnesses.

Disease History (please check all that apply and add the date)

☐ Chicken Pox (Varicella)		☐ Bronchiolitis		☐ Botulism	
☐ Measles Rubeola		☐ Pneumonia		☐ Scarlet Fever	
☐ Rubella (German Measles)		☐ Mumps		☐ Rabies	
☐ Haemophilus Influenza		☐ Tetanus		☐ Bacterial Meningitis	
☐ Meningococcal Infection		☐ Diphtheria			
☐ Pertussis (Whooping cough)					

Allergies (please list)

☐ Medication Allergies	Reaction	☐ Food Allergies	Reaction

☐ Medication Allergies	Reaction	☐ Food Allergies	Reaction

Child's Medical & Developmental History (Cont'd)

☐ Other Allergies	Reaction	☐ Other Allergies	Reaction

Are any of these allergies life-threatening? ◯ Yes ◯ No

Please attach care instructions from your physician for any life-threatening allergies.

Miscellaneous Screenings and Tests (please check all that apply and add the date of last screening)

☐ Vision		☐ Developmental		☐ Tuberculosis (PPD)	
☐ Hearing		☐ Aptitude		☐ Sickle Cell Anemia	
☐ Speech		☐ Educational		☐ Other:	

To the best of my knowledge the information contained above is accurate.

Parent initial: _____ Date: _____

Staff initial: _____ Date: _____

Child's Medical Care Provider

Primary physician's name: _____

Primary physician's practice name: _____ Phone: _____

Physician's practice address: _____

City: _____ State: _____ Zip Code: _____

Preferred hospital/clinic for emergency care: _____

City: _____ State: _____ Zip Code: _____

Dentist's name: _____ Dentist's practice name: _____ Phone: _____

Dentist's practice address: _____

City: _____ State: _____ Zip Code: _____

Child's Insurance Provider

Child's health insurance provider: _____ Secondary health insurance provider: _____

Policy number: _____ Policy number: _____

Child's Immunization History (please attach a copy of your child's immunization records)

Child's Medical Care Provider (Cont'd)

		Initials
1.	Prior to enrollment, I must provide the center with updated medical and immunization information for my child. This information is to be kept current and updated in accordance with state child care regulations.	
2.	I agree to provide information to the child care center about my child's conditions, illnesses, allergies or other needs.	
3.	If my child becomes ill with a reportable contagious disease, I understand that he/she will not be able to return until I bring in a physician's note stating that he/she is no longer contagious.	
4.	If my child becomes ill during his/her time at the child care center, the staff will contact me to pick up my child. I will arrange for pick up as soon as possible and no later than 1 hour after being contacted. If I cannot be reached, the staff will contact those listed in the Child Emergency Contact and Release.	

Emergency Medical Authorization & Consent

		Initials
1.	In case of a medical emergency, the staff will attempt to contact me, those listed in the Child Emergency Contact and Initial Release, and lastly my physician.	
2.	In case of a medical emergency, I agree that my child may receive first aid and/or CPR.	
3.	In case of a medical emergency, I permit the transportation of my child to a local hospital or other urgent care facility, if necessary by paramedics or other emergency personnel.	
4.	In case of a medical emergency, I will be responsible for the emergency medical expenses.	
5.	In case of an accidental ingestion of a poisonous substance, I consent to my child being treated as directed by the Poison Control Center.	
6.	I give my permission to this center to apply ☐ sunscreen and ☐ insect repellant to my child. *Please check which products Initial you will permit.*	
7.	I understand that I must supply my own sunscreen and/or insect repellant with a valid expiration date, and it will be labeled with my child's name.	
8.	I ☐ have ☐ do not have special instructions for the application process.	

Parent initial: _____ Date: _____

Staff initial: _____ Date: _____

Rate Agreement and Contract

Child's Name: _____ Birth Date: _____

Hours of Operation

	Initials
Regular operating hours are except closings for various holidays, and inclement weather as described in the Parent Handbook. Please consult the current calendar for holidays. There is no reduction in tuition as a result of center closures, unless confirmed by director.	
The procedure to notify families should severe weather or other conditions prevent the program from opening on time or at all will be announced on . If it becomes necessary to close early, we will contact you or someone listed in the Emergency Contact and Release, and it will be your responsibility to arrange for your child's early pick up.	

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Scheduled Attendance

The days and hours that I wish to contract for child care are as follows:

Day of week	Start time	AM/PM	End time	AM/PM	Comments
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					

I would prefer to make tuition payments on a ☐ weekly ☐ bi-weekly ☐ monthly basis

Fee Policy (to be completed by staff, reviewed and initialed by the parent/guardian/sponsor after completion)

Initials

- ☑ Starting on _____ a fee of $ _____ is due ☐ weekly ☐ bi-weekly ☐ monthly _____
- ☑ Tuition is due and payable by ☐ Every Monday per week; prior to child care services. _____
  ☐ The 1st and 15th of the month or next business day.
  ☐ First business day of the month.
- ☑ Tuition is not subject to discounts for holidays, emergency closures (i.e., weather), or absence. _____
- ☑ I agree to pay the full tuition in advance of services rendered. _____
- ☑ I agree to pay the full tuition fee even if my child is absent for one or more days. _____
- ☑ A late fee of $5.00 is due if tuition is not received on time and fee will continue daily until credited in full. _____
- ☑ A non-refundable registration fee of $50 00 is due yearly. _____
- ☑ A late pick up fee of $1.00 per minute per child is due if my child is not picked up before contracted schedule time. _____
- ☑ Accounts one weeks in arrears may result in immediate termination of service. _____
- ☑ My child may have the opportunity to participate in a special program or field trip that may have an additional fee duo before the day of the event A specific permission slip may be required. _____
- ☑ All returned checks or ACH transactions (automatic debits) will be charged a fee of LSG bank charges. Two or more returned checks or ACH transactions will result in my account being placed on "money order only". _____
- ☑ A two week written notice is required for any child being withdrawn from the program. Failure to provide notice in writing will result in forfeiture of deposit. _____
- ☑ A receipt for income tax purposes ☐ will ☐ will not be provided. _____

Other Agreements

Child's Name: _____ Birth Date: _____

Private Employment Acknowledgement and Release	Initials
☑ Any arrangement/employment between me and staff of this center (i.e., babysitting), outside of the programs and services offered by this center, is an individual endeavor and private matter not connected to or sanctioned by this center. This center shall remain harmless from any such arrangement.	_____
Media Release	
☑ Occasionally, photos will be taken of the children at the center for use within the center or on our website and/or newsletters. Please indicate that you authorize the use and reproduction of photographs of your child in conjunction with the program.	_____
Walking Excursions	
☑ I give my permission for my child to participate in supervised walking excursions near and around the center.	_____
Handbook Acknowledgement	
☑ I give my permission for my child to participate in supervised walking excursions near and around the center.	_____
☑ I understand and agree that it is my responsibility to read and familiarize myself with policies and procedures outlined in Initial the Family Handbook and agree to abide by them.	_____
☑ I understand that it is my responsibility to go directly to management with any questions I may have regarding the policies and procedures and information contained in this Enrollment Agreement.	_____
☑ Information contained in the Family Handbook may be subject to change.	_____

Contract Approval

I certify that I have read, understand, and accept all of the terms and conditions described in this Enrollment Agreement.

Primary Parent/Guardian/Sponsor Signature: _____ Date: _____

Center Staff Signature: _____ Date: _____

OCFS-LDSS-4433 (Rev. 06/2019)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician Assistant or Nurse Practitioner

Name of Child:	Date of Birth: / /	Date of Examination: / /

Immunizations required for entry into day care

Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s). ☐ Yes ☐ No

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	5th Date / /
Polio (IPV or OPV)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Haemophilus influenzae type B (Hib)	1st Date / /	2nd Date / /	3rd Date / /	4th Date **OR** 1st Date (if given on or after 15 months of age) / /	
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Hepatitis B	1st Date / /	2nd Date / /	3rd Date / /		
Measles, Mumps and Rubella (MMR)	1st Date / /	2nd Date / /			
Varicella (also known as Chicken Pox)	1st Date / /	2nd Date / /			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date: / /	Type of Immunization:	Date: / /
Type of Immunization:	Date: / /	Type of Immunization:	Date: / /
Type of Immunization:	Date: / /	Type of Immunization:	Date: / /

Tests

Tuberculin Test Date: / / Mantoux Results: ☐ Positive ☐ Negative _____ mm

TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: / /

Attach lead level statement

Lead Screening (Include All Dates and Results)

1 year / / Result: _____ mcg/dL ☐ Venous ☐ Capillary

2 years / / Result: _____ mcg/dL ☐ Venous ☐ Capillary

Most recent date of lead screening (if different from above):

/ / Result: _____ mcg/dL ☐ Venous ☐ Capillary

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely. If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

(Continued on reverse side)

CHILD IN CARE MEDICAL STATEMENT *(continued)*

Health Specifics		Comments
Are there allergies? (Specify)	☐ Yes ☐ No	
Is medication regularly taken? (Specify drug and condition)	☐ Yes ☐ No	
Is a special diet required? (Specify diet and condition)	☐ Yes ☐ No	
Are there any hearing, visual or dental conditions requiring special attention?	☐ Yes ☐ No	
Are there any medical or developmental conditions requiring special attention?	☐ Yes ☐ No	

Summary of Physical Exam

Include special recommendations to child day care providers

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care. ☐ Yes ☐ No

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

( ) - Phone

/ / Date