NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DAY CARE REGISTRATION

School _____
AM _____
# of days _____
What days _____
PM _____
# of days _____
What days _____

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

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:

Provider/Day Care Facility Name and Address:

SOUTH ORANGE FAMILY YMCA PRE-SCHOOL DAY CAMP

TOPICAL OINTMENT & ANTISEPTIC FORM

In an effort to protect your child's safety we ask you to review the information below and initial all that is applicable to your child. Please write **NO (** on each line) for any items that you do not want us to use on your child.

I give South Orange Family YMCA permission to apply the following on my child whenever it is deemed necessary.

Please initial all that apply

- Sun Screen _____
- Bacitraycin Cream _____
- Antibacterial Soap _____
- Antibacterial Wipe _____
- Hydrogen Peroxide _____
- Hydrocortisone Cream _____

In initialing the above, I give permission to have these items applied on my child _____ whenever it is deemed necessary.

Please Print Child's Name

_____
Please Print Your Name

_____
Please Sign Your Name

_____
Date

PERMISSION TO ADMINISTER MEDICATION

I _____ give the
Parent or Guardian's Full Name (Please Print)

South Orange Family YMCA Preschool Camp permission to Administer _____
Child's Full Name (Please Print)

the medication designated below. I understand that any medication must be in its original vile. Prescriptions must have the child's name and dosage instructions on the label. Any over the counter medication will only be given if it is deemed age appropriate, unless we are provided written administration directions from a physician. No medication will be given if it is out of date or tampered with in any way.

Medication To Be Administered

Medication_____

Reason for Medication?_____

_____

Dosage_____

Time_____

Date(s) to be given_____

Any special instructions?_____

_____

_____ _____

Parent or Guardian' Signature Date