OCFS-LDSS-0792 (10/2018) FRONT

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 Date of Enrollment: / /	*For Program Use Only* Date of Disenrollment: / /

OCFS-LDSS-0792 (10/2018) 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 (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: / /

the YMCA

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FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA CAMP WEE DISCOVER
PERMISSION TO ADMINISTER MEDICATION

I _____ give the YMCA Camp Wee Discover
Parent or Guardian's Full Name (Please Print)

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/Guardian Signature Date

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YMCA CAMP WEE DISCOVER
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 YMCA Camp Wee Discover 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 Name

_____
Please Sign Name

_____
Date