

PHOTO OF CHILD (Optional)		NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES DAY CARE ENROLLMENT				
		PROGRAM NAME: La Petite Kinder		ADDRESS: 257 Berry Hill Rd		PHONE NUMBER: (516) 715 - 5144
		CHILD'S FULL NAME: PREFERRED NAME/NICKNAME:			DATE OF BIRTH: / /	GENDER:
		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: () - <input type="checkbox"/> ok to text			ADDRESS OF PERSON ENROLLING CHILD (IF DIFFERENT THAN CHILD):			
EMAIL ADDRESS:						
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: / /
Check boxes below to indicate if your child has any special needs/services: <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 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 care information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: https://nystateofhealth.ny.gov/		
AGREEMENTS <ul style="list-style-type: none"> • 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: / /

