Registration Packet

Child's Name: _____Child's DOB _____

Parent Name: _____Phone: _____ Email: _____

Beach Kids Daycare Registration Check List

*PLEASE DO NOT CHECK BOXES_ ADMIN ONLY

1) Emergency Procedure Acknowledgment/Sick Policy/No medication/Release number___
2) Diaper Prep Consent/Photo Consent/Food consent _____
3) Napping Agreement_____
4) Schedule/Payment Agreement/Signatures of received documents____
5) Child Profile_____

6) 0792 Blue card_____
7) 6010 Non-Medication Consent____
   Sunscreen _____
   Diaper Rash _____
   Other_____
   7006(Health plan) _____ (if applicable)
   6029 (Allergy/Anaphylaxis emergency plan) _____ (if applicable)

8) 4433 Child in Care Medical Statement___

9) Copy of Handbook_____
10) Registration fee_____
11) Security Deposit_____
12) Supplies_____

Start Date_____

End Date_____

Medical due_____

Medical Due_____

Medical Due_____

Medical Due_____

Parent Contract for Childcare Services

Payment Agreement

My child, _____ will be attending Beach Kids Daycare for childcare services beginning on_____ (start date) for _____days per week, for a monthly fee of $_____payable in advance on the 1st of each month. Tuition is always paid in advance. There will be **a $75.00 non-refundable registration fee**, as well as a **2-week security deposit** payable upon registration of your child (to be applied towards your child's last 2wks. of care at Beach Kids).

____I agree care is given and paid on a month-to-month basis. I agree that I will not leave in the middle of the month and/or before or after holiday breaks/school vacations/personal vacations and/or sickness. If I must disenroll my child, I agree I will be responsible for paying the full month.

___I agree to pay my child's tuition amount in full, regardless of personal vacation time, school vacation time, occasional sicknesses, a natural disaster/acts of God, state lock down, public health emergency, snow days or any other unforeseen circumstances. I understand no allowances, credits, refunds, makeups shall be made for occasional absences. In the event that we need to close due to a local/statewide emergency issued, tuition will be reduced to half your contracted tuition rate, to keep your child enrolled.

___I agree that a late fee of $20.00 will be applied if payment is not received, for each day unpaid. I agree and understand that if my account is delinquent for more than 2 weeks, I may be asked to withdraw my child until my account is made current.

___I agree that once my child is withdrawn, his/her spot is not guaranteed upon return. My child will only be eligible for readmission based upon availability.

I agree my child will not be able to re-enroll if a 2-week notice was not given or if my account is not current. I agree that any unpaid fees may be sent to a third-party collection agency. I agree my security deposit will be held if terms are not followed.

___I agree to pay a $35.00 service fee for all checks returned by the bank.

I agree that if I pick up my child after scheduled closing, I will be charged a late fee of $1.00 per minute, until my child is picked up. I understand that if my child attends full-time, a 10% discount is offered for each additional child from the immediate family.

___I understand that I must provide a 2-week written notice of withdrawal or change of schedule/change of contract. I understand, the director will provide a

2-week departure notice after the two weeks if my child is withdrawn.

Schedule Agreement

Security Deposit: _____ (2 weeks) Pd. on_____via_____

Registration Fee: $75.00. Pd. on_____via_____

Monday_____ Time: _____

Tuesday_____ Time: _____

Wednesday___ Time: _____

Thursday_____ Time: _____

Friday_____ Time: _____

I have read and agree with the terms stated above.

Parent Signature: _____ Date: _____

Directors Signature: _____ Date: _____

Emergency Procedures Acknowledgement

For the safety of our attending children, we require that the authorization of this form be completed and kept on file at Beach Kids. In emergency situations, the authorization granted by this form will only be used when absolutely necessary and only after every attempt has been made to contact the parent/guardian or other emergency contact. As you know, time can be a crucial factor to your child when medical attention is needed and this form will assist your child in receiving prompt medical attention.

In case of an emergency, I _____ hereby authorize the doctor or the hospital which my child or children may be brought and whomever they may designate as their assistant(s), to perform any emergency procedure or operation, and to give treatment and the administration of anesthetic as deemed necessary in an emergency situation to my child during his/her stay in the program.

Parent Signature: _____ Date: _____

Parent Name_____ Parent Signature _____

Name of Child _____ Relation to Child_____

Date of Birth_____ Age_____ Gender_____

Address of Child_____

Phone Number/s: _____ _____

Emergency Contact_____ Phone # _____

Alternative Emergency Contact_____ Phone #_____

Sick Policy

___Beach Kids Daycare will only allow WELL children in their program. Well children are non-sick children who do not have any symptoms of illness, are not contagious, or a risk to other children and staff. If a child becomes sick and therefore absent, a doctor's note is required upon return.

___I understand that I will be notified if my child becomes ill during the day, and will be required to arrange a prompt pick-up for my child. *Only a parent and/or an authorized emergency contact/release person will be permitted to pick up my child upon such notification.

___If my child is exposed to, or contacts a contagious disease, I agree to notify Beach Kids. I understand that my child will only be allowed to return, once cleared by a doctor, and must provide a doctor's note.

____I understand that absolutely no medication can be administered by the staff at Beach Kids.

Parent Signature: _____ Date: _____

Release of Phone Number/E-Mail Address

Beach Kids may distribute a class list, as well as share your phone number and/or e-mail address amongst families for possible play dates, birthday parties, etc.

____I consent

____I do not consent

phone number_____

e-mail address _____

Parent signature _____Date_____

Photo/ Social Media Consent

I_____, **DO** or **DO NOT** (circle one) grant authorization for Beach Kids to take pictures of my child, and post the pictures to Beach Kids' website and Social Media pages, such as Facebook and Instagram.

To add us on **Facebook**, search: *Beach Kids Daycare and Early Learning Center*

To add us on **Instagram**, search: *Beach Kids Early Learning Center*

Diaper Change/External Preparations Consent

I _____give my permission for the staff at Beach Kids Daycare to diaper change and/or assist (child's name) _____ with toileting when needed. I understand that my supplies (i.e. diapers, wipes, diaper cream etc.) will be used as directed on my child and that diaper changing/toileting will be done according to the child's needs. I also understand that my child's diaper will be changed quickly as possible if it becomes soiled. I agree to supply an extra change of clothes, wipes, diapers and any other supplies needed.

Please put an X next to what applies to your child:

Potty Training _____ Potty Trained _____
Pull Ups _____
Diapers _____
Assistance with wiping needed _____

I, _____ give permission for the staff at Beach Kids to apply one or more of the following external/topical preparations in accordance with the directions for use, provided on the packaging; baby wipes, bandages, Neosporin, Hydrocortisone, Bacitracin, or similar first aid sprays, non-prescription ointments such as A&D, and sunscreens. A non-medical consent form for each external/topical preparation is required. *Absolutely no medications can be administered by any staff member at Beach Kids.

Parent signature _____Date_____

Napping Agreement

I, _____ understand that my child, _____ will sleep on a MAT, provided by Beach Kids. The Mats will be sanitized after each use. I am responsible for providing Beach Kids with either a flat sheet and blanket, or a sleep mat, that will lay on top of the school mat. My child's sheets, blankets, and/or sleep mat will be sent home at the end of each week for cleaning, and will return with my child at the beginning of each week.

Room doors where a child naps, will remain open at all times. A staff member will always remain in the same room, and/or within sight of the sleeping children.

Parent signature _____Date_____

School Food/Cooking Class/Birthday Parties

I, _____ give consent for my child to participate in cooking classes, birthday and/or holiday parties, and consume foods outside of packed lunches.

Parent signature _____Date_____

Epinephrine (EPI) Pen (**Only complete if applicable)

Staff who have been instructed on the use of the epinephrine auto-injector, diphenhydramine, asthma medication or nebulizer will be present during all hours the child with the potential emergency condition is in care and must be listed on the child's Individual Health Care Plan. The staff administering the epinephrine auto-injector, diphenhydramine, asthma medication or nebulizer must be at least 18-years old, unless the administrant is the parent of the child. Staff will immediately contact 911 after administering epinephrine. If an inhaler or nebulizer for asthma is administered, a staff member must call 911 if the child's breathing does not return to normal after its use. Storage, documentation of administration of medication and labeling of the epinephrine auto-injector, asthma inhaler and asthma nebulizer must be in compliance with all appropriate regulations.

My child _____ will keep an epinephrine auto-injector at the facility.

Parent signature _____Date_____

Directors Signature: _____ Date: _____

Child Profile

Name of Child_____DOB_____

Parent Name and Occupation_____ _____

Parent Name and Occupation_____ _____

What foods does your child especially like? _____

Especially dislike? _____

What does your child's typical meal schedule look like? _____

_____

_____

Favorite toys, games, activities? _____

Is your child potty trained? _____ Potty training? _____ Word used for potty: _____

Does your child nap at home? _____ If yes, what is your child's normal nap routine and schedule?

_____

How does your child express anger or frustration? _____

Does your child have specific fears? _____

When your child is upset what helps to comfort him/her? _____

_____

Is there a specific toy or blanket for naptime? _____

What is your child's favorite outdoor activity? _____

_____

Does your child have any health problems and/or allergies that we should be aware of? _____

Special family situations? _____

_____

_____

Five words to describe your child's personality (you are welcome to elaborate): _____

_____

_____

Anticipated adjustment problems? _____

_____

Does your child receive any special services, or has he/she ever been evaluated for any special services?

_____

_____

Any developmental or language delays/disorders diagnosed or suspected? _____

_____

Has your child previously attended daycare or any childcare program? Was it a positive experience?

_____

_____

Any concerns at the previous daycare or program? _____

_____

Please share anything else you would like us to know about your child below.

OCFS-LDSS-0792 (08/2019) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DAY CARE ENROLLMENT

PHOTO OF CHILD (Optional)

PROGRAM NAME: Beach Kids Daycare	ADDRESS:	PHONE NUMBER: ( ) -
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 Child	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	*FOR PROGRAM USE ONLY*
DATE OF ENROLLMENT: / /	DATE OF DISENROLLMENT: / /

OCFS-LDSS-0792 (08/2019)
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 (Please 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 care 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

OCFS-6010 (5/2015)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

NON-MEDICATION CONSENT FORM

Child Day Care Programs

- This form may be used when a parent consents to having over-the-counter products administered to their child in a child day care program. These products include, but are not limited to: topical ointments, lotions and creams, sprays, sunscreen products and topically applied insect repellant.
- This form should NOT be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays. OCFS Form 7002 would meet the consent requirements for medications.
- One form must be completed for each over-the-counter product. Multiple products cannot be listed on one form.
- This form must be completed in a language in which the staff is literate.
- If parent's instructions differ from the instructions on the product's packaging, permission must be received from a health care provider or licensed authorized prescriber.

PARENT TO COMPLETE THIS SECTION (#1 - #14)

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:
4. Name of product (including strength):	5. Amount to be administered:	6. Route of administration:
7A. Frequency to be administered, include times of day if appropriate: ***OR*** 7B. Identify the conditions that will necessitate administration of the product (signs and symptoms must be observable prior to administration):		
8A. Possible side effects: See product label for complete list of possible side effects (parent must supply) ***AND/OR*** 8B: Additional side effects:		
9. What action should the child care provider take if side effects are noted: Contact parent Other (describe):		
10A. Special instructions: See package insert for complete list of special instructions (parent must supply) ***AND/OR*** 10B. Additional special instructions:		
11. Reason(s) for use (unless confidential by law):		
12. Parent name (please print):	13. Date authorized:	
14. Parent signature: **X**		

DAY CARE PROGRAM TO COMPLETE THIS SECTION (#15 - #21)

15. Program name:	16. Facility ID number:	17. Program telephone number:
18. I have verified that #1, -#14 are complete. My signature indicates that all information needed to administer this product has been given to the child day care program.		

19. Staff's name (please print):	20. Date received from parent:
21. Staff's signature: **X**	

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

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