ENROLLMENT CHECKLIST

Child's Registration Date: _____ Child's Start Date: _____

Child's Full Name: _____ Child's Age: _____ Child's DOB: _____

Child's Gender: Male Female Unspecified

Parent/Guardian: _____ Full Address: _____

I have enrolled my child in the following program: From: _____ a.m. / p.m. to _____ a.m. / p.m.

Days: Monday Tuesday Wednesday Thursday Friday

- [ ] Day Care Enrollment
- [ ] Child in Care Medical Statement
- [ ] Enrollment Information
- [ ] Enrollment Agreement
- [ ] Sleeping and Napping Agreement
- [ ] Sunscreen (Non-Medication Consent)
- [ ] Topical Ointment/Cream (Non-Medication Consent)
- [ ] Authorization for Medication (if applicable)
- [ ] Infant Feeding Schedule Agreement
- [ ] Individual Health Care Plan (*for child with special health care needs)*

Bright and Early Discoveries

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: / /

Bright and Early Discoveries

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

Enrollment Information

At the Bright & Early Discoveries Child Care, we provide a healthy, happy and loving family environment just as you would like for your child. We want you to feel secure and have a peace of mind about your child while you are at work, home or school. We are committed to provide the highest quality of professional childcare in your absence. We believe that open communication and mutual respect is the key to a happy, long-lasting relationship between a childcare provider and the child's parents. Please feel free to keep us informed of anything that affects your child and we will do the same. Please make a copy of the agreement for yourself if you wish to. I have received and read the attached child-care contract and rules and agree to comply with all the rules and responsibilities stated in them:

Parent/Guardian Signature: _____	Date: _____
Provider/Director Signature: _____	Date: _____

Child Information

Child's Name (Last, First, Middle Initial): _____

Name Child Goes By: _____ Primary Spoken Language: _____

Child's Address: _____ City: _____ State: _____ ZIP Code: _____

Date of Birth: _____/_____/_____ Gender: ◯ Male ◯ Female ◯ Unspecified

Parent/Guardian Marital Status: ◯ Married ◯ Divorced ◯ Separated ◯ Widowed ◯ Single

Child's Primary Residence: _____

List the family members your child lives with - include names and ages of siblings:

_____

_____

My Child's Medical Care Providers:

Health Insurance Provider: _____ Policy Number: _____

Physician/Clinic Name: _____ Phone: _____

Physician Address: _____ City: _____ State: _____ ZIP Code: _____

Date of Child's Last Physical: _____/_____/_____

Dentist Name: _____ Phone: _____

Dentist Address: _____ City: _____ State: _____ ZIP Code: _____

If the doctor is not available, the child will be taken to the nearest hospital emergency room for treatment. Nearest Hospital: _____

EMERGENCY RELEASE AGREEMENT _____

I hereby give my consent to Bright & Early Discoveries (Child Care Provider) to authorize medical, surgical, and/or dental treatment including hospitalization for my child(ren) _____ while they are in care.

Important Care Information

Eye Color: _____ Hair Color: _____ Ethnicity: _____ Gender: _____

Identifying Marks: _____

Are there any court-ordered custody arrangements for your child? ◯ Yes ◯ No

**If yes, you must provide a copy*

Please list any special medications or health care needs; *please note that children with special needs must have a current health care plan on file with the Center prior to the start of enrollment and it must be updated every six months. The health care plan will be required before starting and the child's start date will be determined based on the ability to assess, prepare, and train for proper and safe care.*

⚠ **List of Allergies & Known Reactions:** _____

Are any of the allergies severe or life-threatening? ◯ Yes ◯ No If yes, please specify:

_____

_____

Does your child have a special need? ◯ Yes ◯ No

Explain special services or accommodations needed which are different from those provided by the Center's routine program (i.e., exercises, equipment, materials, or special services personnel):

_____

_____

Is there anything else we need to know about your child to ensure he or she can be well-supported by our staff?

_____

_____

Parent/Guardian Information

Name: ______________________ Relationship: ______________

Address: ______________________ City: __________ State: ______ ZIP Code: ______

Preferred E-mail Address: ______________________

Cell Phone: ______________________ Home Phone: ______________

Employer: ______________________ Business Phone: ______________

Primary Spoken Language: ______________________

Government Issued Identification: __________ (Type) __________ (Number) __________ (Issuing State)

Parent/Guardian Information

Name: ______________________ Relationship: ______________

Address: ______________________ City: __________ State: ______ ZIP Code: ______

Preferred E-mail Address: ______________________

Cell Phone: ______________________ Home Phone: ______________

Employer: ______________________ Business Phone: ______________

Primary Language: ______________________

Government Issued Identification: __________ (Type) __________ (Number) __________ (Issuing State)

Name: ______________________ Relationship to Child: ______________

Address: ______________________ City: __________ State: ______ ZIP Code: ______

Cell Phone: ______________________ Home Phone: ______________

Government Issued Identification: __________ (Type) __________ (Number) __________ (Issuing State)

Contact in an Emergency: ○ Yes ○ No

Name: ______________________ Relationship to Child: ______________

Address: ______________________ City: __________ State: ______ ZIP Code: ______

Cell Phone: ______________________ Home Phone: ______________

Government Issued Identification: __________ (Type) __________ (Number) __________ (Issuing State)

Contact in an Emergency: ○ Yes ○ No

Name: ______________________ Relationship to Child: ______________

Address: ______________________ City: __________ State: ______ ZIP Code: ______

Cell Phone: ______________________ Home Phone: ______________

Government Issued Identification: __________ (Type) __________ (Number) __________ (Issuing State)

Contact in an Emergency: ○ Yes ○ No

Bright and Early Discoveries will not release your child to anyone who appears impaired. If an impaired person attempts to pick up your child, pick-up will be refused, and we will attempt to contact the other parent/guardian or authorized persons. If alternative arrangements cannot be made, the local child protective services agency and/or the local police will be called, as required by state licensing.

Today's Date: _____ **Start Date / Transition Date:** _____

What would you like us to call your child? _____

Parent/Guardian Name: _____

Parent/Guardian Name: _____

Family Information

Please list the names of family members residing with the child. Please include siblings, extended relatives, and pets. For each person listed, provide the name the child uses to address the indicial and include ages of siblings.

Name	How Child Addresses Them	Age *(if minor)*

Please tell us about cultural family customs, rituals, or traditions that will help us make your child's experience more meaningful, including languages spoken at home:

_____

_____

Has your child had any experience with group care? If yes, please describe:

_____

_____

How does your child react to new situations and new children and adults?

_____

_____

Has your child had previous childcare experience? If yes, explain how it met, or did not meet your expectations?

_____

_____

Child's favorite activities and toys:

_____

_____

Developmental History

What languages does your child speak? _____

Do you have developmental concerns about your child?

_____

_____

Does your child have any speech difficulties? ◯ Yes ◯ No If yes, please explain:

_____

_____

How does your child communicate their needs?

_____

_____

Nutrition Practices and Routines

List special dietary requests and restrictions:

_____

_____

Bright and Early Discoveries

Enrollment Agreement

PARENT-PROVIDER MUTUAL AGREEMENT

It is our sincere desire to provide responsible and loving care for your child. You should feel confident that your child will be safe and happy with us. Bright & Early Discoveries will work with you to help your youngster develop emotionally, physically, socially and mentally at his/her developmental stage. We will also work with your child to enhance their individuality and independence. It is understood that each child is to be treated as equal to the provider's own. We welcome your suggestion and input so that you are completely happy and comfortable with your childcare arrangement. We offer programs for infants, toddlers, preschoolers, pre-kindergarten and before/aftercare.
The following agreement should keep our relationship mutually satisfactory.

The following is an agreement between _____ and Bright & Early Discoveries.

MEDICAL ACKNOWLEGEMENTS_____

1. **Health Records & Immunizations** I will provide Bright and Early Discoveries with updated health & immunization information or an exemption for my child (where applicable by law) prior to the start of enrollment and will maintain these records accordingly.
2. **Illness** II understand that I will be notified should my child become ill during the day and that I will pick up my child promptly (within 60 minutes) or plan for an authorized pick up to do. Failure to pick up my children within the hour may result in late pick-up fees. I understand that my child may return only when he/she is well, as described in the Family Handbook.
3. Infants (6 weeks to 18 months) may not attend school if they had received shots that same day.
4. **Injuries** If my child sustains a minor injury during care, I will be notified and receive an Accident/Incident Report describing the incident when I pick up my child. I will be contacted immediately for all medical/dental emergencies, the injury produces swelling, is on the face or hear, or requires medical attention.
5. **Emergencies** In case of an emergency, I understand that Center staff will attempt to contact me immediately. I also authorize Bright and Early Discoveries' staff to:

- Consult the physician or dentist named above.
- Administer first aid and/or cardiopulmonary resuscitation.
- Transport my child via ambulance or other emergency medical service to a local hospital or other urgent care facility.
- Obtain any emergency medical, surgical, or dental treatment deemed necessary by medical authorities.
- Transport my child to a local emergency shelter in the event of an emergency evacuation of the facility.

PHOTOGRAPHY PERMISSION _____

Bright and Early Discoveries Learning Center, LLC takes care that any use, display, or dissemination of photographs or videos of children is accomplished in a thoughtful and safe manner. Bright and Early Discoveries Learning Center, LLC regularly takes photographs of children enrolled. They may be shared with you and other families in a variety of ways: through ProCare, Facebook, or in a newsletter. They may also be used to better communicate with families, to illustrate the daily curriculum, to chronicle a child's development, or to document BED activities. Additionally, they may be used for other BED, general business, and marketing purposes, including online and social media. Bright and Early Discoveries Learning Center, LLC retains all rights, title, and interest in these materials and may use and disseminate them in a variety of ways, in its sole judgment. Please note, BED is not permitted to allow partial permission for photography usage.
_____ I give permission to Bright and Early Discoveries Learning Center, LLC to take photographs of my child and use these materials as described above.
_____ I do NOT give permission to Bright and Early Discoveries Learning Center, LLC to take photographs of my child and use these materials as described above.

DRESS CODE___

My child will be dressed according to weather conditions and in comfortable play attire.

WALK PERMISSION ____

Bright and Early Discoveries Learning Center, LLC may go on supervised walks with staff in the surrounding area. I will be notified in advance of all trips outside of our licensed premises. These include children taking walks and infants strolling in their buggy. Children may be taken to the areas displayed on the Parent Information Board in the Center's lobby area, which
are not a part of our licensed premises:
_____ I give permission for my child to participate in walks.

FIELD TRIP & TRANSPORTATION_____

(*FOR PARENTS/GUARDIANS OF CHILDREN AGES 4 YEARS OLD AND OLDER ONLY)*
I give the Center permission to transport my child for the purposes of field trips that require bus transportation and/or transportation to or from his or her local school.
_____ Not applicable

NUTRITION PLAN AGREEMENT _____

Bright and Early Discoveries Learning Center, LLC provides the following meals:

- Day Care Center: Breakfast/A.M. Snack/P.M. Snack
- Family Day Care Home/Group Family Day Care: Breakfast/A.M. Snack/Lunch/P.M. Snack

If no parent meal has been provided and I am unable to provide one prior to mealtime, the facility will ensure my child has received a meal.

Bright and Early Discoveries

Enrollment Agreement

PAYMENT OF FEES____

- Cash (receipt will be provided)
- Check (made payable to Bright & Early Discoveries)
- Online
- Zelle

ACCOUNT/CARD ON FILE

MANDATORY - Any delinquent accounts will be automatically charged to the account/card on file on the first of the month.

REGISTRATION FEE

A non-refundable registration fee of $_____ is due at time of registration. A re-registration fee is due annually and is subject to change. A summer camp registration fee is due at time of summer camp registration. If your child withdraws from the program and later re-enrolls registration is still due.

TUITION_____

Based on the child's regular schedule. I will be charged additional tuition if my child's attendance increases beyond this schedule. If my child's schedule changes in any way, I will notify the administration immediately. Tuition and fees are not prorated for illness, holidays, or emergency closures. (See Family Handbook for illness, holidays, or emergency closures.) I agree to pay the full tuition even if my child is absent for one or more days, except for the prearranged "Absence/Va even if my child is absent for one or more days, except for the prearranged "Absence/Vacation"cation" time.

- Scheduled times and days are established at enrollment. A $30.00 fee will be billed to your account for late drop off/late pick up after 3 occurrences.

SIGNING IN/OUT_____

I agree to sign my child in/out every day using the facility's attendance procedures.

DROP IN_____

In order to accommodate our working parents, we allow a one-time unscheduled day added to your child's scheduled days. A drop-in day should be paid for upon request. A drop-in day cannot be used in exchange for one of your child's scheduled days; it is an addition to what your child is already scheduled for.

If your child's scheduled days fall on a holiday or a day your child cannot attend in can not be exchanged.

FINANCIAL ACKNOWLEDGMENTS_____

Returned payments for non-sufficient funds will be charged $50.00 service fee.

SCHEDULE CHANGES_____

Tuition rates will be adjusted to reflect any permanent change in hours. I am required to give one month's notice in writing of any change in my child's schedule. Tuition will be reduced thirty days after notice is received. If my child's schedule increases or decreases, Bright and Early Discoveries cannot guarantee that a space will be made.

ABSENCES *There are no make up days.*

If your child will be absent on a particular day, please notify Administration no later than 9 AM via an acceptable form of communication. Administration should also be notified in advance if your child will be out for multiple days due to illness, vacation, or other family activities.

ABSENCE/VACATION CREDIT _____

Each child will receive a one-week vacation credit per calendar year. To receive this credit, you must be in attendance for a minimum of six (6) months consecutively. Notification of vacation must be completed at least 14 days in advance. My child may not attend when taking the vacation credit. Credit cannot be carried over into next year.

LATE FEES_____

A late fee of $_____ will be added to my child's tuition if it is not paid by 1st of next month.

LATE PICK-UP FEE _____

A late pick-up fee of $50.00 per half hour per child will be assessed when my child is left beyond the child's schedule or if not picked up in a timely manner for illness . The late pick-up fee does not constitute an agreement to provide after hour services.

CHILD NOT PICKED UP____

If I fail to pick up my Child and/or contact Bright and Early Discoveries, and I or another authorized person cannot be reached within 30 minutes after closing time, Center staff may release my child to the custody of child protective services or other local authorities.
I will be charged $5.00 per minute or any portion thereof from closing time until the time my child is picked up.

HOLDING FEE

If we would plan on being absent for an extended period, but would like to hold my child's spot, I may pay a holding fee. The holding fee is one half of one month's tuition for each month that your child is absent from the facility to guarantee re-entry.

SIBLING DISCOUNT____

Families with two or more children enrolled full-time at Bright and Early Discoveries are eligible for a 10% discount to be applied to the lesser child's monthly tuition.

COMMUNICATIONS _____

I give Bright and Early Discoveries Learning Center, LLC permission to communicate with me by telephone, text, e-mail, or other means. I understand BEDs privacy policy applies to the information I provide.

COLLECTIONS

Any accounts that have outstanding balance after 3 months will be reported to collections.

WITHDRAWAL FROM PROGRAM _____

A minimum of two week's written notice is required prior to the last day of attendance (Refer to Enrollment Agreement for specific notice period requirements). If I do not give written notice of withdrawal, I agree to pay full tuition and fees due for the required notice period regardless of my child's attendance.

ADA NOTICE_____

Bright and Early Discoveries, LLC does not discriminate based on disability in the admission/enrollment or access to our programs or services. Information concerning the provisions of the Americans with Disabilities Act (ADA) including the rights provided thereunder is available from the Director/Director.

FAMILY HANDBOOK RECEIPT_____

I have received a copy of the Family Handbook. I have read and understood its contents and policies and agree to be bound by the same.

Thank you for entrusting Bright & Early Discoveries and its staff with your child's early childhood education. If you have any questions about this agreement, please speak to the administration at any time. These policies have been reviewed with me by Bright and Early Discoveries Administration. I understand and will comply with these policies included in the Family Handbook. The policies in this contract will supersede all other previous documents previous documents.

Parent / Guardian Legal Name

Relationship to Child

Signature

Date

Role

Signature

Date

Bright and Early Discoveries 

SLEEPING AND NAPPING AGREEMENT

Sleeping and napping arrangements must be made in writing between the parent and the childcare provider. The provider shall maintain this completed agreement on file in the facility. This arrangement is required by New York State Child Day Care (OCFS).

I, _____ (parent/guardian's name), understand that my child _____(child's name), while under the care Bright & Early Discoveries, will be napping on a (cot/crib/mat) in the _____ classroom. I understand that while my child is napping, there will be competent supervision at all times, via direct supervision of a caregiver who is in the same room and has direct visual contact with my child.

If my child is an infant, I also understand that my child will be placed on his/her back to sleep in a crib. I must provide a medical note from my child's pediatrician if another sleeping arrangement must be made due to a health condition my child may have. I understand that if my infant falls asleep in a swing, or bouncer, he/she will immediately be moved to a crib. In addition, the sleeping and napping agreement must be updated as the child moves from one classroom to another. If a child is unable to sleep during the classroom's scheduled nap time, my child will be provided with a quiet activity.

Electronic devices cannot be implemented during this time of day (Tablets/iPads), as per NYS OCFS Child Daycare Regulations.

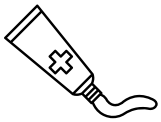
It is recommended that parents of all Preschool and PreK children provide a nap mat (ask administration)

Signature of Parent/Guardian
Name (please print): _____
Signature:_____
Date: _____

Signature of Child Care Provider
Name/Title (please print): _____
Signature:_____
Date: _____

Bright and Early Discoveries

TOPICAL OINTMENT/CREAM



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:
BRIGHT AND EARLY DISCOVERIES	*816075*	*631-591-9060*

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

Bright and Early Discoveries

SUNSCREEN
(no sprays please!)

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:
BRIGHT AND EARLY DISCOVERIES		

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

Bright and Early Discoveries 

INFANT FEEDING SCHEDULE AND PARENT AGREEMENT

All bottles, cups, and utensils must be labeled with child's full name. Powdered formula, ready to feed milk, juice and breast milk must be pre-measured and labeled with child's full name and expiration date.

_____ Parent prepares formula
_____ Provider prepares formula

Please choose one of the following options for your infant:
_____1. I will provide ALL Formula, solid food, and juice for my infant.
_____2. I will accept the provider's offer to supply meal components for my infant child.

Please Initial
I _____ give the provider permission to add warm sterilized water to powdered formula.
I _____ give the provider permission to warm milk in a bottle warmer.
I _____ give the provider permission to warm solid food.

I want my infant child to be fed according to the following schedule (please check one):

- On Demand
- As requested _____
  _____

<u>Signatures on this form imply that both parties understand</u>

- Children 6 months of age and under must be held during all bottle feedings
- Microwave heating of infant food and formula is prohibited by regulations.
- The Child Care Provider will make every effort to accommodate the needs of a child who is
- breast-fed.

Parent's Signature _____ Date _____
Provider Signature _____ Date _____

Bright and Early Discoveries

OCFS-LDSS-7006 (07/2022) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

You may use this form or an approved equivalent to document an individual health care plan developed for a child with special health care needs.

A child with a special health care need means a child who has a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and who requires health and related services of a type or amount beyond that required by children generally.

Working in collaboration with the child's parent and child's health care provider, the program has developed the following health care plan to meet the individual needs of:

CHILD NAME:	CHILD DATE OF BIRTH: / /
NAME OF THE CHILD'S HEALTH CARE PROVIDER:	☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner

Describe the special health care needs of this child and the plan of care as identified by the parent and the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment.

Identify the caregiver(s) who will provide care to this child with special health care needs:

Caregiver's Name	Credentials or Professional License Information (if applicable)

Bright and Early Discoveries

OCFS-LDSS-7006 (07/2022) REVERSE

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

Describe any additional training, procedures or competencies the caregiver identified will need to carry out the health care plan for the child with special health care needs as identified by the child's parent and/or the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment. In addition, describe how this additional training and competency will be achieved including who will provide this training.

This plan was developed in close collaboration with the child's parent and the child's health care provider. The caregivers identified to provide all treatments and administer medication to the child listed in the specialized individual health care plan are familiar with the child care regulations and have received any additional training needed and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

PROGRAM NAME:	FACILITY ID NUMBER:	PROGRAM TELEPHONE NUMBER:
BRIGHT AND EARLY DISCOVERIES		( )
CHILD CARE PROVIDER'S NAME (PLEASE PRINT):		DATE: / /
CHILD CARE PROVIDER'S SIGNATURE: **X**		

I agree this Individual Health Care Plan meets the needs of my child. Yes ☐ No ☐

I give consent to share information about my child's allergy with all program caregivers in a non-discreet way. I support the strategies the program implements to keep my child from being exposed to known allergen(s). I acknowledge these strategies may include visual reminders that may result in the disclosure of my child's confidential allergy information to non-child care staff. Yes ☐ No ☐

Signature of Parent:

X	DATE: / /

Bright and Early Discoveries

OCFS-LDSS-7006 (07/2022) REVERSE

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

Describe any additional training, procedures or competencies the caregiver identified will need to carry out the health care plan for the child with special health care needs as identified by the child's parent and/or the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment. In addition, describe how this additional training and competency will be achieved including who will provide this training.

This plan was developed in close collaboration with the child's parent and the child's health care provider. The caregivers identified to provide all treatments and administer medication to the child listed in the specialized individual health care plan are familiar with the child care regulations and have received any additional training needed and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

PROGRAM NAME:	FACILITY ID NUMBER:	PROGRAM TELEPHONE NUMBER:
BRIGHT AND EARLY DISCOVERIES		( )
CHILD CARE PROVIDER'S NAME (PLEASE PRINT):		DATE: / /
CHILD CARE PROVIDER'S SIGNATURE: **X**		

I agree this Individual Health Care Plan meets the needs of my child. Yes ☐ No ☐

I give consent to share information about my child's allergy with all program caregivers in a non-discreet way. I support the strategies the program implements to keep my child from being exposed to known allergen(s). I acknowledge these strategies may include visual reminders that may result in the disclosure of my child's confidential allergy information to non-child care staff. Yes ☐ No ☐

Signature of Parent:

X	DATE: / /

Bright and Early Discoveries
LEARNING CENTER

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We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT AND CREDIT CARD

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____

FOR OFFICIAL USE ONLY

Date Received

Employee Signature

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