



Child's Full Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Child's Home Address	Date of Birth
	Home Telephone Number
Date of Acceptance	Date of Discharge
Name of Person Applying for Child	<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Caretaker <input type="checkbox"/> Relative <input type="checkbox"/> Other _____
Home Telephone Number	Daytime Telephone Number
Address of Person Listed Above (If Different from Child's)	

<p>Agreements</p> <p>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 services provided by the facility and the Office of Children and family Services regulations under which it operates.</p> <p>I give consent for my child to take part in neighborhood field trips (i.e. library, park, playground) away from the facility under proper supervision. <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>In case of accident or injury, I authorize any and all emergency medical, dental, and/or surgical care and hospitalization advisory 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. <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>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. <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>I agree to review and update the information whenever a change occurs and at least once every six months. <input type="checkbox"/> yes <input type="checkbox"/> no</p>	
Signature of Parents or Person(s) Legally Responsible	Date

Please complete front and back.

New York State
Office of Children and Family Services
Day Care Registration

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 Medical Care/Primary Care Physician's Name			Telephone Number
Child's 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 NUMBER (Check Type)
			<input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work
			<input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work
			<input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work