NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DAY CARE ENROLLMENT

PHOTO OF CHILD (Optional)

PROGRAM NAME:	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 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: ☐ 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

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:	DATE: / /

The Learning Academy of St. Mark's

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Weather/Emergency Contact Sheet

Child's Name: _____ Date of Birth: _____

Teacher: _____

Parent Name: _____ Cell Phone: _____

Place of Work: _____ Work Phone: _____

Parent Name: _____ Cell Phone: _____

Place of Work: _____ Work Phone: _____

The people listed below are the emergency contacts authorized to pick up my child. In the event of an emergency where both parents can **NOT** be reached, the following people have the authority to pick up my child once they have provided photo identification. (Please complete the information)

Name: _____ Phone #1: _____

Address: _____ Phone #2: _____

_____

Name: _____ Phone #1: _____

Address: _____ Phone #2: _____

_____

Name: _____ Phone #1: _____

Address: _____ Phone #2: _____

_____

Parental Consent:

In the event of inclement weather or emergency, I give my permission for The Learning Academy of St. Mark's to release my child to any of the above mentioned people once they have provided photo identification.

_____ _____

(Print Name) (Signature)

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School Food Policy and Agreement

Dear TLA Family,

This letter is being sent home to inform you of our "School Food" policy here at The Learning Academy.

The Learning Academy of St. Mark's is a **"Peanut and Nut Free School."** Please be mindful of our students who have allergies. Please do not send in peanut butter or products containing nuts. If you are going to be celebrating birthdays and/or special occasions and wish to send in a special treat, please make sure that those food products do not contain nuts.

Also, to help ensure the safety of our students, the following food **MUST be cut into quarters** in order to be served.

***Carrots**
***Hot Dogs**
***Grapes**
***Blueberries**

If the above mentioned foods are not cut up, they will not be served.

Please be mindful that we are "teaching" our kids every minute of the day and teaching them "Healthy Eating Options" is one of our goals. When you are planning a celebration or special visit, please keep in mind that healthy options are just as yummy and fun!

We apologize for any inconvenience this may cause but we strive to make our school a safe environment for all of our students.

Please sign and return this form to school acknowledging that you are aware of our school policy. As always, we thank you so much for your continued cooperation and support!

Miss Morgan

Student Name:_____

Parent Signature:_____

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Health Suggestions and Guidelines

When your little one is under the weather and has any of the following symptoms, it is school and state policy for them to **stay home** until they are symptom free **WITHOUT MEDICATION** for **24 hours**. If your child has...

*A fever within the last 24 hours

*Vomiting within the last 24 hours

*Diarrhea within the last 24 hours

*Nasal and/or eye discharge especially if it is green/yellow in color

*Any chills, body aches, sore throat

*A bad cough, especially bad enough to keep them from getting a good night's sleep

If your child is out for 3 or more days or has either of the following, a doctor's note will be required in order for them to return to school...

*Any kind of rash/reaction on their skin

*Head lice- please be sure to notify the school so that we can make other families aware to appropriately eliminate the situation

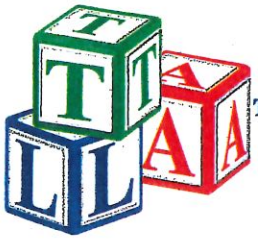
If your little one gets sick at school, we will contact you and/or their emergency contact to arrange pick up.

We appreciate your understanding and cooperation in these situations. While we totally understand that little ones get sick, we make every effort to contain the illness as quickly and easily as possible. Keeping students and staff healthy and happy is our main goal!

Please sign and return one copy to TLA

Student Name: _____

Parent Signature: _____



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HIPAA Consent and Release Form

Student Name: _____ Date of Birth: _____

I hereby authorized _____ to
(Health Care Provider's Name and Telephone Number)

release my child's health information/history to The Learning Academy of St. Mark's. I give permission for you to consult with their faculty so that appropriate and safe care will be given to my child pertaining to their health care/needs and medications.

Parent Name: _____

Parent Signature: _____ Date: _____

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Student Medical Statement

To Be Completed By Licensed Physician, Physician's Assistant or Nurse Practitioner

Name of Child:	Date of Birth:	Date of Examination:

Immunizations required for entry into day care ☐ Yes ☐ No

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).

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.

(Form continued on reverse side...)

... Student 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

Religious Exemptions

Public Health law Section 2164 allows a child to be religiously exempted from immunization. A written and signed statement from a parent, parents or guardian of the child stating that they object of the immunization of their child due to their sincere and genuine religious beliefs should be submitted to the day care owner, operator or administrator who shall determine whether the statement of religious belief is acceptable.

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Photo Release/Permission

I hereby give permission for my child to be photographed by The Learning Academy of St. Mark's. I allow photographs to be used on The Learning Academy's website, brochure, and promotional materials. I also give permission for my child's photo to be posted/used on the school's social media accounts (Facebook, Instagram) in an effort to allow parents to see the daily activities of the school. All social media accounts will be closed to the public and only school families will be granted access.

(Please complete the lower portion and return to school)

☐ I give my permission for my child to be photographed by The Learning Academy of St. Mark's.

☐ I do **NOT** give my permission for my child to be photographed. I do **NOT** want my child's photo taken throughout the school year.

Student's Name: _____

Parent's Name: _____

Parent's Signature: _____

Parent's Email Address: _____