

# ENROLLMENT INFORMATION

I, \_\_\_\_\_, would like to enroll my child, \_\_\_\_\_, at The Alphabet Tree Children's Center. The Alphabet Tree will provide two snacks daily. Parents will supply lunch for their child and breakfast if needed.

My child will attend The Alphabet Tree on the following days and hours:

MONDAY: from \_\_\_\_\_ to \_\_\_\_\_

My child's first day  
will be:

TUESDAY: from \_\_\_\_\_ to \_\_\_\_\_

WEDNESDAY: from \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_

THURSDAY: from \_\_\_\_\_ to \_\_\_\_\_

My child's vacation  
will be \_\_\_\_\_

FRIDAY: from \_\_\_\_\_ to \_\_\_\_\_

& \_\_\_\_\_

I agree to pay \$\_\_\_\_\_ per week for my child/children's care. I understand this rate will remain the same REGARDLESS OF HOLIDAYS, SICK DAYS, OR OTHER DAYS ABSENT. I will give two weeks notice (or pay for two weeks) when removing my child from The Alphabet Tree. Tuition is due on Mondays if paying weekly or the first week of the month if paying monthly. A \$10.00 late fee is incurred if not paid by Friday of each week.

## CHILD CARE RELEASE INFORMATION

The Alphabet Tree will not release your child into the custody of any person you do not specify as an acceptable pick-up person. This includes all family members (except fathers and mothers). Telephone approval is not accepted. Anyone picking up your child must have a photo ID. Please list below all persons who you would like to pick up your child. If not picked up by closing time (5:30 PM) these people may be contacted.

APPROVED PICK-UP PERSON

PHONE NUMBER

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

It is understood that all mothers and fathers have equal rights to pick up their children. If you have a court order stating otherwise, it must be included in your child's records.

It is understood that once a child is released into the custody of one of the above, The Alphabet Tree no longer has any responsibility for that child whatsoever. **It is the parent's responsibility to hold their child's hand when exiting and to keep the child safe in our parking lot when loading the child into and out of the car.**

I have received, read and acknowledged the written policies of the Alphabet Tree.

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(Mother's signature)

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(Father's signature)

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(Director's signature)

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**DAY CARE REGISTRATION**

**PHOTO OF CHILD  
(Optional)**

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 Source of Medical Care/Primary Care Physician's Name:

Telephone Number:

Child's Source of 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 TELEPHONE NUMBER (Check type)
				<input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other
				<input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other
				<input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other
				<input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other

Can your child's photo be used on our web site/newspaper advertisements and articles? (yes) (no)

Provider/Day Care Facility Name and Address:	CHILD'S FULL NAME:		SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female
	CHILD'S HOME ADDRESS:		DATE OF BIRTH:
			HOME TELEPHONE NUMBER:
	DATE OF ACCEPTANCE:	DATE OF DISCHARGE:	
	NAME OF PERSON APPLYING FOR CHILD:		HOME TELEPHONE NUMBER:
	<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Caretaker <input type="checkbox"/> Relative <input type="checkbox"/> Other _____		DAYTIME TELEPHONE NUMBER:
	ADDRESS OF PERSON LISTED ABOVE: (IF DIFFERENT FROM CHILD'S):		
	<b>AGREEMENTS</b> 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 the services provided by the facility, and the Office of Children and Family Services regulations under which it operates.		
	I give consent for my child to take part in neighborhood trips (i.e. library, park and playground) away from the facility under proper supervision. <input type="checkbox"/> Yes <input type="checkbox"/> No		
	In case of accident or injury, I authorize any and all emergency medical, dental, and /or surgical care and hospitalization advised 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		
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			
I agree to review and update this information whenever a change occurs and at least once every six months. <input type="checkbox"/> Yes <input type="checkbox"/> No			
SIGNATURE - PARENT OR PERSON(S) LEGALLY RESPONSIBLE		DATE:	



# Medical Statement of Child in Childcare

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

Name of Child:	Date of Birth:	Date of Examination:
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## Immunizations

**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

DPT / DT	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date	Booster Date	Booster Date
Polio	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date	Booster Date	Booster Date
Hib (conjugate preferred)	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date	4 <sup>th</sup> Date	
Hepatitis B	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date		
MMR	1 <sup>st</sup> Date	2 <sup>nd</sup> Date			
Varicella / Chicken Pox	1 <sup>st</sup> Date	2 <sup>nd</sup> Date			

## Other Immunizations

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.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: \_\_\_\_\_  
 Attach lead level statement

## Health Specifics

## Comments

Are there allergies? (Specify) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is medication regularly taken? (Specify drug and condition) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is a special diet required? (Specify diet and condition) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any hearing, visual or dental conditions requiring special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any medical or developmental conditions requiring special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No	

ADDITIONAL INFORMATION ON REVERSE SIDE →



# Medical Statement of Child in Childcare (cont.)

## Summary of Physical Exam

Include special recommendations to Day Care Providers

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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 day care.

Yes  No

<hr/>	
Signature of Examiner	Address
<hr/>	
Please Print Name	City, State, Zip
<hr/>	
Title	(      ) Phone
	Date

## Religious Exemptions

In accordance with Public Health Law, the sincere religious beliefs of the child's parents prohibit immunization. Do you wish to exercise those rights?  Yes  No

Any child not fully immunized for any reason must be excluded from care whenever there is an outbreak. The child may return only upon approval of the local county health department.

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Signature of Parent or Person Legally Responsible	Date