

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

PHOTO OF CHILD (Optional)	Child's Full Name:			
	Does your child have allergies? <input type="checkbox"/> Yes <input type="checkbox"/> 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's Health Plus? <input type="checkbox"/> Yes <input type="checkbox"/> No		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced		
EMERGENCY DATA	RELATIONSHIP	CONTACT NAME	TELEPHONE# DURING CHILD CARE	OTHER TELEPHONE# (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
				<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

OCFS-LDSS-0792 (1/2005) FRONT

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OFFICE OF CHILDREN AND FAMILY SERVICES
DAY CARE REGISTRATION

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EMERGENCY DATA	RELATIONSHIP	CONTACT NAME	DAYTIME PHONE #	OTHER TELEPHONE# (Check type)
				<input type="checkbox"/> Cell <input type="checkbox"/> Other
				<input type="checkbox"/> Cell <input type="checkbox"/> Other
				<input type="checkbox"/> Cell <input type="checkbox"/> Other
				<input type="checkbox"/> Cell <input type="checkbox"/> Other
				<input type="checkbox"/> Cell <input type="checkbox"/> Other
				<input type="checkbox"/> Cell <input type="checkbox"/> Other
				<input type="checkbox"/> Cell <input type="checkbox"/> Other

OCFS-LDSS-0792 (1/2005) FRONT

Provider/Day Care Facility YWCA of Jamestown 401 North Main Street Jamestown, NY 14701 (716) 488-2237	CHILD'S FULL NAME:		DOB:	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female
	CHILD'S HOME ADDRESS:			HOME TELEPHONE#:
			CELL TELEPHONE#:	
DATE OF ACCEPTANCE:		DATE OF DISCHARGE:		DATE OF RE-ENROLLMENT:
Applicant's Work Information (During hours of Day Care) Employer: Address: City/State/Zip: Personal Email:	NAME OF PERSON APPLYING:	APPLICANT'S RELATIONSHIP <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Caretaker <input type="checkbox"/> Relative <input type="checkbox"/> Foster Care <input type="checkbox"/> Other _____	RACE/ETHNIC IDENTITY <input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> White/African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Hispanic/African American <input type="checkbox"/> Asian-Pacific Islands <input type="checkbox"/> Am Indian – Alaskan Native <input type="checkbox"/> Other	
	ADDRESS OF PERSON LISTED ABOVE: (IF DIFFERENT FROM CHILD'S):			
AGREEMENTS 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:	
			SECURITY CODE:	

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