

Child's Name _____

School Year _____

Clarkstown Central School District Childcare and Early Learning Program

Forms Checklist

Items/Forms	Parent ✓	Director ✓
Registration Application		
Emergency Information Form		
Tuition Check	Due when school starts: N/A if doing payroll deduct.	
Tuition Policy Statement		
Payroll Deduction Form		
Pick Up Permission Form		
Handbook Receipt & Nap Agreement		
Medical Statement of Child		
Formula Permission Form		
Diapering Ointment Form		
Photo Release Form		
Sunscreen Form		

- Payroll deduction is only available to Clarkstown School District Employees.
- If you do not have an infant enrolled in the program, mark n/a for the Formula Permission Form.
- If your child is not using diapering ointment, mark n/a for Diapering Ointment Form.

Clarkstown Central School District
Childcare and Early Learning Program

Sandra Condon, Program Director
scondon@ccsd.edu

Registration Application

Date: _____

Child's Full Name _____ DOB: _____

Address: _____

City _____ State _____ Zip _____

Home Phone: _____

Name Parent 1 _____ Name Parent 2 _____

Do both parents reside together? _____ If not, please provide alternative address:

Do both parents have unrestricted access to the child? If not, please explain:

Parent 1 work information: _____ Social Security # _____

Occupation: _____ Work Hours: _____

Company Name & Address _____

Company Main # _____ Direct Line _____

Cell Phone # _____

E-mail Address _____

Parent 2 work information: _____ Social Security # _____

Occupation: _____ Work Hours: _____

Company Name & Address _____

Company Main # _____ Direct Line _____

Cell Phone # _____

E-mail Address _____

In the event that you need to be contacted regarding your child, who should be called first? _____

Which phone number is best (#, direct line, or cell phone)? _____

Alternate person to contact in an emergency: _____

Address: _____ Relationship: _____

Home # _____ Work # _____ Cell # _____

Physician/Pediatric Group: _____

Address: _____

Telephone # _____ Fax: _____

Child's General Health: _____

Dietary Restrictions: _____

Allergies: _____

Please describe your previous childcare arrangement, if any: _____

Is your child toilet trained? _____

Siblings & Ages: _____

Comments to help us know your child better:

I hereby grant Clarkstown Central School District Permission to use my personal information to contact me via the school's emergency communication system. I acknowledge that my contact information will be used for this purpose.

Parent/Guardian Signature

Date

Should you wish to withdraw your child from our program, one (1) month written notice must be submitted to the Program Director. Mid-month withdrawals will not be accepted. Withdrawal notice must be submitted no later than the 1st day of the previous month if you wish to withdraw your child.

Parent/Guardian Signature date

Parent/Guardian Signature date

CCSD Childcare & Early Learning Program

Emergency Information Sheet

Child's Full Name _____ D.O.B. _____

Sex: ____ male ____ female Date of Acceptance _____ Date of Discharge _____

Address _____

Home Phone _____

Parent 1 Name _____

Parent 2 Name _____

Work # _____

Work # _____

Cell # _____

Cell # _____

Name of Person Applying for Child _____ Relationship _____

Address (if different from child) _____

Home Phone _____ Cell # _____

In the event that I cannot be reached, these are alternative emergency contacts:

Name _____ Relationship _____

Home # _____ Cell # _____

Name _____ Relationship _____

Home # _____ Cell # _____

Physician/Pediatric Group _____ Phone # _____

Child's Dentist _____ Phone # _____

Name of Preferred Medical Facility or Hospital _____

List any Health Conditions: (allergies, medications, special diet, etc.) _____

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 require health 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 childcare provider.

Agreements: I consent to the enrollment of the child listed above in this facility and have been advised of the policies regarding the 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.

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 (identified above) necessary for the proper health and well-being of my child. ____yes ____ no

I have provided information on my child's special needs (allergies, diet, disabilities, or medical info) to the provider, as may be necessary to assist them in caring for my child in the event of an emergency. I agree to update this info when it changes or at least every 6 months. **Parent/Guardian Signature** _____ **Date** _____

Clarkstown Central School District
Childcare and Early Learning Program

Sandra Wirchansky, Program Director
swirchansky@ccsd.edu
(845) 213-9489

Tuition Policies

For enrollment to be finalized, all fees and necessary forms are required to be submitted prior to your child's first day at our program.

Should you wish to withdraw your child from our program, one (1) month written notice must be submitted to the Program Director. Mid-month withdrawals **will not** be accepted. Withdrawal notice must be submitted in writing no later than the 1st day of the previous month if you wish to withdraw your child.

Tuition is due by the first (1st) of each month. **Payroll deduction is strongly encouraged. Please complete a payroll deduction form to secure arrangements.** Your child may be denied attendance if tuition is not paid by the fifth (5th) of any month. Late fees of \$25 per month will be charged after the fifteenth (15th) of the month. Checks should be made payable to **Clarkstown Central Schools Childcare Program.**

Any check that is returned from the bank will incur a fee of \$35.00. Please refer to the Parent Handbook for further information regarding enrollment.

CCSD Childcare and Early Learning Program must be informed of any changes related to the information in your child's folder. Should a change in information occur and we are not informed, the program cannot be held liable for any decisions regarding your child's well being.

If our center closes for facility or weather related problems, parents are responsible for the full tuition.

By signing below, I state that the information submitted for my child's folder, including but not limited to the medical statement and emergency information sheet, are true to the best of my belief. Additionally, I agree to the Policies and Procedures of CCSD Childcare and Early Learning Program, as outlined in the Parent Handbook Agreement.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Clarkstown Central School District
Childcare and Early Learning Program
Sandra Condon, Program Director
scondon@ccsd.edu
(845) 213-9489

Payroll Deduction Form for Tuition

I would like to have the monthly childcare tuition for my child(ren) deducted from my current salary. I authorize the payroll office to deduct the amount needed to cover the monthly tuition cost. I hereby agree that if my employment with Clarkstown Central School District is terminated for any reason, I am obligated to pay in full any outstanding balance due the District by certified check before the release of my final paycheck(s).

Amount being deducted PER CHILD:

- **Pre-K 4s Program** monthly fee is \$700 per month
\$700 will be divided evenly and deducted from each paycheck through June
- **Pre-K 3s Program** monthly fee is \$1250 per month
\$1250 will be divided evenly and deducted from each paycheck through June
- **Toddler Program** monthly fee is \$1300 per month
\$1300 will be divided evenly and deducted from each paycheck through June
- **Infant/Toddler Transition Room** monthly fee is \$1400 per month
\$1400 will be divided evenly and deducted from each paycheck through June

of children on Pre-K 4s pay schedule (\$700 per month) _____

of children on Pre-K 3s pay schedule (\$1250 per month) _____

of children on Toddler pay schedule (\$1300 per month) _____

of children on Infant/Toddler Transition pay schedule (\$1400 per month) _____

Total Monthly Payment being deducted: _____

Child's Name(s) _____

Your Full Name, please print _____

Employee ID # (found on paycheck) _____

Home Telephone Number _____

School Location _____

Signature _____

Date _____

Child's Name _____

Clarkstown Central School District
Childcare and Early Learning Program
Sandra Condon, Program Director
scondon@ccsd.edu

Parent 1 Name: _____ cell# _____

Parent 2 Name: _____ cell# _____

Child Pick Up Permission Form

In the event that I am unable to pick up my child at the end of the day, he/she may be released to the following persons:

Names

Telephone Numbers

1. _____ home # _____

cell # _____

2. _____ home # _____

cell # _____

3. _____ home # _____

cell # _____

I understand that my child will not be released to anyone other than these three people unless I have notified the program in advance.

Parent Signature

Date

Photo Release Permission Form



I, _____, parent of _____

hereby consent to grant authorization to the Clarkstown Central School District (District) to use my child's photograph for the adornment of bulletin boards within District premises, publication on the District website and/or Seesaw app, or inclusion in the District's promotional materials. I acknowledge that my child's identity shall not be linked with their image when disseminated on the District website and/or the Seesaw application or in other District promotional content. Furthermore, I understand that such photographs will be shared and/or maintained in a designated community folder, either via Google or one of our communication platforms, accessible solely to the parent/guardians of the respective class through exclusive invitation.

Parent/guardian Signature

Date

I, _____, parent of _____,

DO NOT consent to grant authorization for Clarkstown Central School District (District) to use my child's photograph for any purpose.

Parent/guardian Signature

Date

Clarkstown Central School District
Childcare and Early Learning Program

Parent Handbook Receipt Confirmation

Child's Name _____

Parent's Name _____

I hereby acknowledge that I have received a copy of the Parent Handbook from the CCSD Childcare and Early Learning Program. I understand that the policies and procedures are articulated within and I agree to abide by the communicated guidelines and expectations.

Signature _____ Date _____

*CCSD Childcare & Early Learning Program
Napping Agreement*

- It is understood that all children who nap will remain in their respective classrooms for nap/rest time. Nap mats are placed on carpeted areas of the classroom.
- Infants nap in cribs and toddlers/preschoolers nap on nap mats.
- Nap time is supervised in accordance with NYS OCFS staffing regulations, Sec. 418-1.8

Sandra Condon, Director



Name of Child _____

Parent Signature _____

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 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)	1 st Date	2 nd Date	3 rd Date	4 th Date	5 th Date
Polio (IPV or OPV)	1 st Date	2 nd Date	3 rd Date	4 th Date	
Haemophilus influenzae type B (Hib)	1 st Date	2 nd Date	3 rd Date	4 th Date OR 1 st Date (if given on or after 15 months of age)	
Pneumococcal Conjugate (PCV) for those born on or after 1/1/08)	1 st Date	2 nd Date	3 rd Date	4 th Date	
Hepatitis B	1 st Date	2 nd Date	3 rd Date		
Measles, Mumps and Rubella (MMR)	1 st Date	2 nd Date			
Varicella (also known as Chicken Pox)	1 st Date	2 nd 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.
 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.

ADDITIONAL INFORMATION ON REVERSE SIDE →



Medical Statement of Child in Childcare

(continued)

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	

Summary of Physical Exam

Include special recommendations to 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 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.

Clarkstown Central School District
Childcare and Early Learning Program

Formula Preparation Permission Form
Breast Milk Instructions

My baby drinks (check one)

_____ formula

_____ breast milk

_____ mixed formula and breast milk

I hereby grant permission to the staff of the CCSD Childcare and Early Learning Program to prepare my child's formula according to the label instructions. I will provide formula in original containers and the water with which it is to be mixed (if in powder form).

How many ounces are given per feeding? _____

When should formula be given? _____

Child's Name _____ Parent Signature _____

Date _____

Breast milk: If you are breastfeeding, please discuss your preferences for serving and storing your milk with the teacher.

Use these questions to guide your conversation:

- How many ounces of milk are served at a feeding? _____
- How often does your baby get a bottle? _____
- Are you mixing breast milk with formula? _____
- How will your milk be stored? _____
- If a baby does not finish a bottle at any particular feeding, what would you like us to do with the milk? _____

Child's Name _____ Parent's Signature _____

Date _____

DIAPERING OINTMENT

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 repellent.
- 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: <input type="checkbox"/> 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: <input type="checkbox"/> Contact parent _____ Other (describe): _____				
10A. Special instructions: <input type="checkbox"/> 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: CCSD childcare		16. Facility ID number: 733098		17. Program telephone number: 845-213-9489
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				

SUNSCREEN FORM

OCFS-6010 (5/2015)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
NON-MEDICATION CONSENT FORM
Child Day Care Programs

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- 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: <input type="checkbox"/> 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: <input type="checkbox"/> Contact parent _____ Other (describe): _____					
10A. Special instructions: <input type="checkbox"/> 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: <i>CCSD Childcare</i>		16. Facility ID number: <i>733098</i>		17. Program telephone number: <i>845-213-9489</i>	
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): <i>Sandra Condon</i>			20. Date received from parent:		
21. Staff's signature: <i>Sandra Condon</i> X					