

## Tiny Town Application for Enrollment

Date: \_\_\_\_\_

### Child's Information

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Street Address: \_\_\_\_\_ Sex: M or F

City, State, Zip: \_\_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_

Approximate Start Date: \_\_\_ / \_\_\_ (D/M) Distinguishing Marks: \_\_\_\_\_

Allergies or other Special Needs of Child: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_

Age Group:      Infants      Toddlers      Preschool (3 yrs)      Pre-K (4 yrs)

Expected Hour of Arrival: \_\_\_\_\_ Expected Hour of Departure: \_\_\_\_\_

### Mother/Guardian Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Work Address: \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Normal Work Hours: \_\_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_ Email Address: \_\_\_\_\_

### Father/Guardian Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Work Address: \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Normal Work Hours: \_\_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_ Email Address: \_\_\_\_\_

### Siblings (if applicable)

Sibling Name(s) and Age(s): \_\_\_\_\_

\*If you would like to be added to our private Facebook group, please see Jackie for more information

## Infant and Toddler Information

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### Eating Patterns

\*Check each of the following that pertain to your child:

Breast fed ( ) Bottle ( ) Warmed ( ) Cup ( ) Spoon ( ) Fork ( ) Bowl ( ) Plate ( )

Fingers ( ) Strained Foods ( ) Baby Foods ( ) Table Foods ( ) Formula ( ) Milk ( )

Other: \_\_\_\_\_

Food Likes: \_\_\_\_\_ Food Dislikes: \_\_\_\_\_

Allergies: \_\_\_\_\_ Feeding Problems: \_\_\_\_\_

Eating Schedule (times, types, and amounts)

Breakfast: \_\_\_\_\_ Mid-Morning Snack: \_\_\_\_\_

Lunch: \_\_\_\_\_ Afternoon Snack: \_\_\_\_\_

Dinner: \_\_\_\_\_

### Sleeping Patterns

\*Check each of the following that pertain to your child:

Sleeps Well ( ) Doesn't Sleep Well ( ) Back ( ) Stomach ( ) Pacifier ( )

Security Blanket/Toy ( ) Bottle ( ) Rocked ( )

Napping Schedule (times & amounts)

Nights (between 7:00pm and 7:00am): \_\_\_\_\_

Morning Naps (between 7:00am and 12:00pm): \_\_\_\_\_

Afternoon Naps (between 12:00pm and 7:00pm): \_\_\_\_\_

Has your baby shown any sleeping problems? \_\_\_\_\_

Does your baby usually cry before going to sleep? \_\_\_\_\_

Does your baby cry when waking up? \_\_\_\_\_

Is your baby accustomed to absolute quiet when sleeping? \_\_\_\_\_

Language Development

How does your child tell you what they want?

Gestures: \_\_\_\_\_

Words: \_\_\_\_\_

Sentences: \_\_\_\_\_

Medical Concerns

Please list all allergies and their reactions: \_\_\_\_\_

\_\_\_\_\_

Has your child had injuries, operations, or health related problems that we need to be aware of?

\_\_\_\_\_

Has your child had any serious or reoccurring illness? \_\_\_\_\_

\_\_\_\_\_

Are there any activities your child cannot participate in? \_\_\_\_\_

\_\_\_\_\_

Developmental Growth

Age at which your baby...

Crawled on hands and knees \_\_\_\_\_ Sat without support \_\_\_\_\_ Walked without support \_\_\_\_\_

Began eating finger foods \_\_\_\_\_ Said first word \_\_\_\_\_

Used a spoon well \_\_\_\_\_ Used a training cup \_\_\_\_\_

Used a regular cup \_\_\_\_\_ Combined two words \_\_\_\_\_

General Information

What do you consider essential to a quality Day Care Program for your child? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any other special instructions/comments/requests/etc.? \_\_\_\_\_

\_\_\_\_\_

---

---

---

---

Personality

How would you describe your child's personality? \_\_\_\_\_

---

What do you enjoy most about your child? \_\_\_\_\_

---

What do you find troublesome about your child? \_\_\_\_\_

---

What cues should we look for? And what do they tell us? \_\_\_\_\_

---

Are there any situations that frustrate or anger your child? \_\_\_\_\_

---

Diapering:

\*We will only use *disposable* diapers

Approximately how many times do you change your baby between 7:30am and 5:30pm? \_\_\_\_\_

How would you describe your child's bowel movements? Normal ( ) Loose ( ) Hard ( )

\*We will help with toilet training when you feel your child is ready for this milestone. We will work together with you to come up with a plan that is best for your child.

We would like to know your personal philosophy regarding this matter (typically we start this process at 18+ months of age): \_\_\_\_\_

---

---

---

---

---

## Photo Usage Permission Form

Please read the following options, check the box next to your selection, then sign & date this form. (Please be sure to keep a copy for your records).

Note: Photos are to be used for promotional purposes only

---

I give Tiny Town CDC, Inc. permission to post **photos and first name** of my child(ren) on their website and social media sites:

Web: [www.tinytownscotia.com](http://www.tinytownscotia.com)

Facebook: [www.facebook.com/tinytownscotia](http://www.facebook.com/tinytownscotia)

---

I give Tiny Town CDC, Inc. permission to post **photos only** of my child(ren) on their website and social media sites:

Web: [www.tinytownscotia.com](http://www.tinytownscotia.com)

Facebook: [www.facebook.com/tinytownscotia](http://www.facebook.com/tinytownscotia)

---

I **do not** give Tiny Town CDC, Inc. permission to post photos or first name of my child(ren) on their website and social media sites:

Web: [www.tinytownscotia.com](http://www.tinytownscotia.com)

Facebook: [www.facebook.com/tinytownscotia](http://www.facebook.com/tinytownscotia)

*I understand that by selecting this option, my child(ren) will be excluded from all group pictures, advertisements, or online postings.*

---

*Tiny Town CDC, Inc. will make every effort to abide by your wishes. If we accidentally missed a child to be removed from a group picture, or you change your mind about pictures already posted, please allow us 24 hours to remove the photo(s).*

Parent/Legal Guardian Name (Printed): \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Parent Acknowledgement**

I (the undersigned) hereby acknowledge that I have received copies of Tiny Town Day Care Center's Parent Handbook, Health Policies and Parent Information.

I have read the contents and agree to abide by all conditions therein.

Parent/Legal Guardian Name (Printed): \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Director Name (Printed): \_\_\_\_\_

Director Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Emergency Medical Permission**

Child's Full Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Daytime Phone: (\_\_\_\_) \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Daytime Phone: (\_\_\_\_) \_\_\_\_\_

Other Contact \_\_\_\_\_ Daytime Phone: (\_\_\_\_) \_\_\_\_\_

Relationship to Child \_\_\_\_\_

Other Contact \_\_\_\_\_ Daytime Phone: (\_\_\_\_) \_\_\_\_\_

Relationship to Child \_\_\_\_\_

Health Insurance Information: \_\_\_\_\_

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

You have my permission to transport (Child's full name) \_\_\_\_\_ to  
\_\_\_\_\_ hospital and authorize treatment by the doctor on call

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

**Release Permission**

My Child (full name) \_\_\_\_\_ has my permission to leave Tiny Town Day Care Center only with the following people:

Name:	Relationship:	Phone:
_____	_____	( ) _____
_____	_____	( ) _____
_____	_____	( ) _____
_____	_____	( ) _____
_____	_____	( ) _____
_____	_____	( ) _____
_____	_____	( ) _____
_____	_____	( ) _____
_____	_____	( ) _____
_____	_____	( ) _____
_____	_____	( ) _____

I understand that my child will not be released to anyone whose name is not included on this list. Tiny Town's Staff will ask any person(s) unknown to them for proof of identity.

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_



## Biting Policy

In every case of a child biting another child or teacher, the biter's parent(s)/guardian(s) will be notified by way of a daily report or incident report.

The bitten child's parent(s)/guardian(s) will be notified in the same manner.

In no case will the names of the two children involved be made known to anyone other than the staff and management of Tiny Town.

In most cases biting is a stage that a child will go through and Tiny Town Staff will do everything possible (through use of positive discipline, prompts, distancing, teether, etc.) to stop the biting. Cases in which the behavior continues the following will occur:

At the discretion of Tiny Town, an excessive biter's parents will be asked to find other childcare arrangements. This decision will be a last resort, after the parent, the child's physician and Tiny Town Staff have exhausted all resources available to stop the behavior.

In the case of a child's discharge from Tiny Town, the biter's parents will receive a two-week notice (in writing) from Tiny Town's Director.

A previously discharged child's return to Tiny Town will be considered only after ample time has passed and evidence that the child is no longer biting is exhibited. The decision to allow a child's return will be made by Tiny Town's Director and a two-week trial period will be implemented.

Should a previously discharged child return and bite again, the biter's parents will be asked to find other childcare arrangements. The parents will receive a one-week notice (in writing) from Tiny Town's Director and will make no payment for that week in lieu of their deposit held by Tiny Town.

**I have read, understand, and agree with Tiny Town's biting policy stated above.**

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

## Nap Time Policy

On a daily basis the children in all five age groups will have a nap/rest period. In the Infant I and Infant II rooms, the children will nap in their cribs and on their own schedule. Parents are to provide a crib sheet, sleep sack, and/or a light blanket.

In our Toddler, Preschool, Pre-K rooms we try to keep the children on a schedule. Nap time in these rooms are from 1:00pm to 3:00pm. Parents will need to provide a sheet, light blanket, and a small travel sized pillow. Please also provide a reusable bag or backpack to store the bedding in throughout the week (no plastic bags are permitted).

Bedding for all classrooms will be sent home every Friday (or the child's last scheduled day of the week) to be cleaned and returned for the next week.

During nap time, we will continue to maintain our classroom ratios. Either your child's teacher or one of our floating teachers will help supervise the children during this time.

**I have read, understand, and agree with Tiny Town's nap time policy stated above.**

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

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

<b>PHOTO OF CHILD (Optional)</b>	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: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Caretaker <input type="checkbox"/> Relative _____ <input type="checkbox"/> Other _____		
	PHONE NUMBER(S) OF PERSON ENROLLING CHILD: ( ) -			ADDRESS OF PERSON ENROLLING CHILD (IF DIFFERENT THAN CHILD):	
EMAIL ADDRESS: <input type="checkbox"/> ok to text					
<b>EMERGENCY INFO</b>	EMERGENCY CONTACT NAMES / ADDRESSES		Authorized to Pick Up Child	PRIMARY PHONE NUMBER	OTHER PHONE NUMBER / EMAIL
	PRIMARY CONTACT:		<input type="checkbox"/> Yes <input type="checkbox"/> No	( ) - <input type="checkbox"/> ok to text	( ) - <input type="checkbox"/> ok to text
			<input type="checkbox"/> Yes <input type="checkbox"/> No	( ) - <input type="checkbox"/> ok to text	( ) - <input type="checkbox"/> ok to text
			<input type="checkbox"/> Yes <input type="checkbox"/> No	( ) - <input type="checkbox"/> ok to text	( ) - <input type="checkbox"/> ok to text
<b>FOR PROGRAM USE ONLY</b> DATE OF ENROLLMENT: / /			<b>FOR PROGRAM USE ONLY</b> DATE OF DISENROLLMENT: / /		

CHILD'S FULL NAME:		DATE OF BIRTH: / /
<b>Check boxes below to indicate if your child has any special needs/services:</b> <input type="checkbox"/> None <input type="checkbox"/> Early Intervention/Special Education <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech/Language <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Allergies (Please list) _____ <input type="checkbox"/> Other _____		
Please provide information here <b>AND</b> 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: ( ) -
<b>Child health care information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: <a href="https://nystateofhealth.ny.gov/">https://nystateofhealth.ny.gov/</a></b>		
<b>AGREEMENTS</b>		
• I consent to emergency medical treatment for my child.....		<input type="checkbox"/> Yes <input type="checkbox"/> 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.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
• I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
• I provided information on my child's special needs to the program to assist in caring for my child.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
• I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation.....		<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 year.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:		DATE: / /

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**CHILD IN CARE MEDICAL STATEMENT**

**To Be Completed By Licensed Physician, Physician Assistant or Nurse Practitioner**

Name of Child: _____	Date of Birth: _____ / /	Date of Examination: _____ / /
----------------------	-----------------------------	-----------------------------------

**Immunizations required for entry into day care**

**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

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

*(Continued on reverse side)*

**CHILD IN CARE MEDICAL STATEMENT *(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 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