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

Developmental History

Child's Name _____ DOB ___/___/___

Personal History

Type of birth: _____ Any complications: _____

Age began sitting: _____ Crawling: _____ Walking: _____ Talking: _____

Any speech problems? _____

Second language spoken in the home? If so, which language? _____

Special words used by your child to describe their needs: _____

_____

Health

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

_____

Any physical disabilities? _____

Please list all allergies and their reactions: _____

_____

Regular or as needed medication(s): _____

_____

Eating

Food allergies: _____

Food likes: _____

Food dislikes: _____

Does your child use: Spoon (___) Fork (___) Hands (___)

Any special instructions: _____

_____

Toileting

Does your child indicate when they need to use the bathroom? _____

Words used for urination: _____ Words used for bowel movement: _____

Any hesitation or apprehensions about training or bathroom? _____

Does your child still have accidents? If so, please describe: _____

_____

Other comments/concerns: _____

_____

Sleep/Nap Habits

Does your child take naps? If yes, at what times and for how long? _____

_____

Average Bedtime: _____ Average awakening: _____ Special/Security Toy: _____

Average mood upon awakening: _____

Social Skills

Does your child have experience in group settings with other children? _____

How about with other caregivers? _____

By nature is your child: Friendly (___) Slightly aggressive (___) Shy (___) Withdrawn (___)

Where does your child play 'well': In Groups (___) Alone (___) Structured Settings (___)

Does your child have any known fears: Animals (___) Strangers (__) Aggressive Children (___)

Darkness (___) Storms (___) Loud Noises (___) Other: (_____)

How does your child cope with this fear? _____

_____

How is your child disciplined at home? _____

_____

How is your child comforted at home? _____

_____

Other comments: _____

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
Facebook: 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
Facebook: 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
Facebook: 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, teethers, 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: _____

OCFS-LDSS-0792 (08/2019) FRONT

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	*FOR PROGRAM USE ONLY*
DATE OF ENROLLMENT: / /	DATE OF DISENROLLMENT: / /

OCFS-LDSS-0792 (08/2019) REVERSE

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: / /

OCFS-LDSS-4433 (Rev. 06/2019)

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)	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.

(Continued on reverse side)

CHILD IN CARE 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