The Nursery School
2579 Motor Parkway
Ronkonkoma, NY 11779

Student Information

Name_____ D.O.B_____

Home Address_____

Mother's Name_____ Cell Phone_____

Father's Name_____ Cell Phone_____

Email_____

Allergies_____

Nickname_____

Does your child prefer left or right hand?_____

Does your child have any special needs?_____

What do you hope for your child to gain from this experience?_____

_____

_____

_____

Would you like to come into our class to read a story, do a craft, bake or share a special talent?

_____

Parent Signature_____ 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

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:
The Nursery School	2579 Motor Parkway, Ronkonkoma	(631) 981 - 5176

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
DATE OF ENROLLMENT: / /

FOR PROGRAM USE ONLY
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-6040 (Rev. 06/2021)

NEW YOK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

COVID-19 HEALTH SCREENING ATTESTATION

The New York State Department of Health Interim Guidance for Child Care Programs requires all individuals to complete a daily health screening questionnaire before arriving to a child care program or upon arrival to a child care program.

If an individual answers “Yes” to any of the screening questions, they cannot enter the child care program, except as otherwise indicated.

Screening Questions:

1. Is your temperature higher than or equal to 100.4 degrees Fahrenheit?

2. Have you had any known close or proximate contact with a person confirmed (by diagnostic test) or suspected (based on symptoms) to have COVID-19 in the past 10 days? Note: Close contact is defined by DOH as being within 6 feet of an individual for 10 minutes or more within a 24-hour period, starting from 2 days before symptom onset or, if asymptomatic, 2 days before the date the positive sample was collected through when they are isolated. Close contact does not include individuals who work in a health care setting wearing appropriate, required personal protective equipment.

Exception: Asymptomatic staff and children may attend if the staff/child is fully vaccinated or has recovered from laboratory confirmed COVID-19 in the previous 3 months and has not been placed on quarantine. Note: Fully vaccinated is defined as being 2 weeks or more after either receipt of the second dose in a 2 dose vaccine series, or 2 weeks or more after receipt of one dose of a single-dose vaccine.

3. Are you currently experiencing or have you recently, (within the past 10 days) experienced ANY COVID-19 symptoms?

Note: *Symptoms may occur with pre-existing medical conditions, such as allergies or migraines. You should only answer "Yes" if your symptoms are new or worsening.*

- Cough
- Shortness of breath
- Trouble breathing
- Fever (equal to or above 100.4 degrees Fahrenheit)
- Chills
- Muscle pain or body aches
- Headache
- Sore throat
- Loss of taste or smell
- Fatigue
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

4. Have you tested positive for COVID-19 through a diagnostic test within the past 10 days?

5. Have you traveled within the past 10 days and not complied with requirements of the New York State Travel Advisory?

Attestation: I agree that I will self-monitor these symptoms each day, report the outcome to the child care program, and not enter any child care program if any of the above symptoms or conditions are present.

X	/ /
Signature	Date
X	/ /
Signature	Date

Note: *This document must be signed and returned to the program prior to entry. A signed copy needs to be provided only once. The child care program must retain a copy for their records.*

Napping Agreement

Dear Parents,
Please Fill our and sign the top OR the bottom. Only the one that applies to you.

I would like my child_____to have a 45-minute nap. I will provide two crib sheets and a small blanket. I understand that I must bring the blanket and sheet home the last day of each week that he/she attends to wash it.
I understand that if my child falls asleep, he/she will be given 15 minutes additional to sleep and then will be gently woken up.

_____ _____
Parent's Signature Date

OR

I would not like my child_____to nap. I understand that he/she will be given a quiet toy to do for 45 minutes.

_____ _____
Parent's Signature Date

LIST OF PERSONS AUTHORIZED TO PICK UP CHILDREN

NYS Regulation:
416.15 (c) (4)
417.15 (c) (4) The provider must maintain on file at the family (group) day care home, available for inspection by the Office or its designees at any time the following:

- the names and addresses of persons authorized to take the child(ren) from the family (group) day care home:

PROVIDER NAME: THE Nursery School

PROVIDER ADDRESS: 2579 Motor Pkwy
RonKonKoma, NY 11779

CONTACT TELEPHONE #: (631- 981 - 5176

PARENT/GUARDIAN NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

NAMES OF CHILD(REN) ENROLLED:

_____
_____
_____
_____

NAMES AND ADDRESS OF PERSON(S) AUTHORIZED TO PICK UP CHILD:

_____ RELATIONSHIP TO CHILD
_____
_____ _____

_____ RELATIONSHIP TO CHILD
_____
_____ _____

_____ RELATIONSHIP TO CHILD
_____
_____ _____

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____ UPDATE AS NEEDED OR AT LEAST ONCE A YEAR