Church Street Community Nursery School

4 Church Street
Red hook, NY 12571
(845)-758-6282
Churchstreet@frontiernet.net

Background Information

Child's Name: _____Nickname: _____
Gender: Male or Female
Home Address: _____
Home Phone: _____ Year entering Kindergarten: _____
Date of Birth: _____ Home School District: _____

Guardian's Name: _____ Occupation: _____
Home Address: (if different) _____
Cell Phone: _____
Email: _____

Guardian's Name: _____ Occupation: _____
Home Address: (if different) _____
Cell Phone: _____
Email: _____

Names & Ages of Siblings

_____ Age _____ _____ Age _____
_____ Age _____ _____ Age _____
_____ Age _____ _____ Age _____

Does your child have any known allergies (food or otherwise)? Be specific:

_____
_____
_____

If an EpiPen is needed on site, additional paperwork will be needed, please contact director.

Has your child received or are they currently receiving any special services? What? _____
_____
_____

Do you have concerns about your child's development? _____
What experiences has your child had away from home? _____
_____
With whom does your child spend time with during the day? _____
_____

What benefits do you hope your child will receive from attending Church Street? _____
_____
_____

Habits

Does your child nap, if so how long? _____ Bedtime hour _____

Does your child tell an adult when they have to use the bathroom? _____

What terminology does your child use (bathroom)? _____

_____

Does your child have any habits that you would like to bring to the teacher's attention (nail biting, temper tantrums, thumb sucking, or attachment to a special blanket)? _____

_____

_____

Discipline

What manner of discipline do you most often rely on? (Time-out, reprimand, warning, etc.) _____

_____

_____

Playtime Interests

Favorite Plaything or activity _____

Does your child play well with others? _____

Does your child play well on their own? _____

What are the ages and relationships of the children your child plays with most frequently? _____

_____

Personality

How would you describe your child's personality and nature? _____

_____

Does your child seek the attention of adults? _____

What are your child's fears? _____

_____

What else would you like to share about your child? _____

_____

Health History

Please **circle** any physical conditions we should know about your child.

*Asthma *Frequent Colds *Sore Throats *Diabetes

*Bronchitis *Seizures *Ear Infections *Stomach Upsets

*Kidney/Bladder Troubles *Heart Issues *Fainting/Dizzy Spells

Please detail any conditions that may affect your child while at Church Street. _____

_____

_____

If your child should develop a contagious condition, please report it to your child's teacher or the Director immediately.

Do you have any special interests or talents you would like to share with the school? _____

_____

_____

Prepared By _____**Date** _____

Church Street Community Nursery School

4 Church Street
Red Hook, NY 12571
(845) 758-6282
churchstreet@frontiernet.net

Parental Consent Form

I give permission for my child, _____ to participate in **ALL** field trips Church Street Community Nursery School plans. This may include but not limited to:

- Walking field trips to the library & Village Hall (3 & 4 year olds)
- Pumpkin Picking, Holy Cow, etc **(you will be asked to provide transportation)**

Please initial next to the following that you give permission for:

_____ I give permission for my child to be photographed by the nursery school. I will allow such photographs to be used for classroom purposes, bulletin board displays, and any other classroom purpose.

_____ I give permission for my child's name and contact information to be shared with other students in the class.

_____ I give permission for my child's picture to be used on Church Street's main Facebook page (this is not a private page), and school website.

_____ I give permission for my child's photo to be posted on the ClassDojo App. (This is a closed app that teachers use for communication. It is only open to parents/guardians in your child's class.

_____ I give permission for the teachers to assist with changing my child's diaper if necessary.

____ No I'd prefer you call me and I will come change my child's diaper.

The following people are allowed to pick up my child in addition to the people listed on the Blue Card:

Name: _____ Relationship to child _____
Phone Number: _____

Name: _____ Relationship to child _____
Phone Number: _____

****Turn Over****

Communication Consent Form

___ I give permission for Church Street Nursery School Staff to discuss information about my child _____with the following:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

___ I do not give permission for Church Street Nursery School Staff to discuss information about my child _____ with anyone other than his/her parent and/or guardian.

I can be contacted by phone: _____ and/or email: _____.

Print Name: _____ Date: _____

Parent Signature: _____

****Turn Over****

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 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-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