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: / /

Field of Dreams Preschool
181 Guinea Hill Road
Slate Hill, NY 10973
(845) 355-3232

PERSONAL HISTORY

Child's Full Name: _____
Language spoken at home: _____

With what does your child usually play?

_____

Are his/her playmates, if any, older/younger? □ Older □ Younger
Does he/she get along with these playmates? □ Yes □ No

What time does he/she usually go to bed? _____
What time does he/she usually get up? _____
Does he/she sleep well? □ Yes □ No
Does he/she stay dry all night? □ Yes □ No
Does he/she take a daytime nap? □ Yes □ No
Does he/she tell an adult when he/she needs to use the toilet? □ Yes □ No
Do you need to remind him/her? □ Yes □ No
Does your child dress him/herself? □ Yes □ No
Can he/she put on his/her coat or sweater? □ Yes □ No
Can he/she button, zipper, put on his/her shoes? □ Yes □ No

Does your child suck his/her thumb or fingers, bite his/her nails, have temper outbursts or any other such habits? □ Yes □ No
Does your child have any special fears? □ Yes □ No
If so, please describe: _____
How does your child behave when angry, upset or afraid?_____
Who is responsible for the discipline of your child?

_____
How is your child disciplined and how does he/she react to discipline?

_____

_____
Is there anything we should know to better understand your child?

_____
_____ What do you hope your child will get out of his/her preschool experience?

_____

_____

Are you planning to car pool? □ Yes □ No If so, with whom:

_____

Field of Dreams Preschool
181 Guinea Hill Road
Slate Hill, NY 10973
(845) 355-3232

Please give the names of two persons we may contact if you are not home:
Name: _____ Relationship: _____
Phone:_____
Name: _____ Relationship: _____
Phone:_____

MEDICAL HISTORY

Child's Name: _____ Date of Birth:
_____ Sex: □ Male □ Female

Address:

_____

_____

_____

Home Phone: _____

Is there any family history pertinent to child's experiences such as: □ divorce □ recent births □ adoption □ other _____

Does your child have ANY allergies? □ Yes □ No
If so, please list them here:

_____

Restrictions, ailments, disabilities or other concerns we should know about:
□ Vision _____
□ Hearing _____
□ Speech _____
□ Diet _____
□ Motor Skills _____
□ Other _____

Please have your child's doctor fill out and sign the Child in Care Medical Statement (attached).

Please read and sign our Health Plan Contract (attached).

Field of Dreams Preschool
181 Guinea Hill Road
Slate Hill, NY 10973
(845) 355-3232

Emergency Medical Consent Form

I give my permission to Deirdre Post to seek emergency treatment for my child: _____ in the event that I cannot be immediately contacted.

Signature of Mother:_____
Date:_____

Signature of Father: _____ Date: _____

Emergency Contact Number: _____

Alternative contact person (relative or neighbor) who may be called when the parents or guardians cannot be reached in case of emergency:

Name: _____

Phone Number: _____

Relation to Child: _____

Field of Dreams Preschool has the following doctor on call:
James N. Wapshare, MDPC
1996 Route 17M Goshen, NY 10924
(845) 291-7059

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

Health Plan Contract for Field of Dreams

We wash our hands many times throughout the day: before snack and lunch; after staff/students go to the bathroom; after indoor and outdoor play times, etc.

In an attempt to maintain a healthy learning environment, all sick children are requested to stay home.

It is important that we do not pass on infections. Children who are sick should be kept at home until infectious stage has passed. Some examples of infections include the following:

Fevers
If your child has had a fever with an oral temperature above the American Pediatric normal range of 98.7 Fahrenheit, he or she must be fever free for 24 hours before returning to school (example: if the fever ends at 7 p.m. Monday, they must not have a fever through Tuesday 7 p.m.). Then they may return Wednesday provided the fever is gone.

Diarrhea
If your child has had three or more stools in a 24 hour period, including watery stools, urine irregularity and dehydration.

Vomiting
Any child who vomits two or more times in a previous 24 hour period or any vomiting accompanied by symptoms of dehydration or other signs of illness.

Rashes
Any child with an undiagnosed rash on face, or any body part must not be brought to school until either the rash disappears or a doctor's note is accompanying the child with diagnosis.

We are a program that only serves well children. Anything out of the ordinary such as wheezing, difficulty breathing, persistent crying or any other signs of illness or symptoms of possible illness should be reviewed by the child's health care professional. A parental conference and/or doctor's note would be needed to ensure the wellness of the child before returning to our program.

It is of the utmost importance that all children attending our program have updated immunizations, lead screening and a release from the doctor stating that he/she is free from communicable diseases. No child will be accepted to our program without these forms.

Please sign and return the bottom portion of this page:

I acknowledge Field of Dreams' Health Policy and agree to abide by its guidelines.

Sign _____

Print _____ Date_____

Field of Dreams Preschool
181 Guinea Hill Road
Slate Hill, NY 10973
(845) 355-3232

Field of Dreams follows the following policy for Universal Pre-Kindergarten (Pending District Approval of Government Grant)

In the event your child is chosen for the NY State Lottery to receive Universal Pre-Kindergarten, please note the following:

1. You will receive:
   *5 half (1/2) days paid for by the Universal Pre-Kindergarten. Parental requests for an AM or PM time slot may be overwritten and the children will be placed solely at the discretion of Field of Dreams.

2. If you are signed up for 5 full days, you will receive:
   *5 half (1/2) days are paid for by the Universal Pre-Kindergarten.
   You will, however, be responsible to pay tuition at the price of the 5 half day sessions.

If you are chosen for UPK and wish to ADD on time, you must contact the office for tuition prices and to make the appropriate arrangements by July 1st.

Parent/Guardian Signature_____
Date_____

In the event you choose not to enroll in Field of Dreams, you must notify us prior to July 1st in order to receive a refund of your deposit (registration fees won't be refunded). If you notify us after July 1st, you will be forfeiting your deposit. In the event you receive Universal Pre-K, your refund check will be issued on November 1st.

Field of Dreams Preschool
181 Guinea Hill Road
Slate Hill, NY 10973
(845) 355-3232

TUITION POLICY

A $40 registration fee is required for students enrolled in any Non-UPK program or any Full Day program.

The first payment for preschool is due July 1st. Please send in all registration papers and 1st month's tuition. We have a **YEARLY TUITION** that is broken down into 10 equal payments.

- 2nd Payment = September 1st
- 3rd Payment = October 1st
- 4th Payment = November 1st
- 5th Payment = December 1st
- 6th Payment = January 1st
- 7th Payment = February 1st
- 8th Payment = March 1st
- 9th Payment = April 1st
- 10th Payment = May 1st will be your Final Payment

We accept cash, check and credit cards (Visa & Mastercard). We ask that you make your payment by the **1st of each month**. If your payment is not received by the 10th of each month, your tuition payment and an additional $15 late fee will be due immediately. *There will be a $35 fee on all returned checks*

If payment is not received by the end of the month, the student may not be allowed to continue in the program until all fees have been paid.
*** **Note**: Field of Dreams reserves the right to fill the slot with children on our wait list if tuition is not paid by the end of the month, unless a prior arrangement has been made with the office. Communication is paramount!

****IMPORTANT NOTICE REGARDING REGISTRATION****

In the event you choose to drop out of the Field of Dreams Program, you must notify us prior to June 15th in order to receive a refund of your deposit, registration fees won't be refunded. If you notify us after June 15th, you will be forfeiting your deposit. In the event you receive Universal Pre-K, your refund check will be issued on November 1st.

I, _____, parent/guardian of,

_____, have read and acknowledge Field of Dream's Tuition Policy for the school year and agree to abide by its terms.

Parent's/Guardian's Signature _____
Date Signed _____

Field of Dreams Preschool
Permission for Internet Publication

Public relations is an important part of our school. Our website and Facebook page includes a variety of information including photos about our school.
Permission to take, display and publish your child's photo is required. We also take pictures of the children at special events, as well as for craft projects.

Student Name: _____

(please check ALL that apply)

- ☐ **I GIVE** permission for Field of Dreams to take/print/display photos of my child (for crafts / projects and special events).

- ☐ I **GIVE** permission for my child's **photo** to be displayed and published on the Field of Dreams website & Facebook page.

- ☐ I **DO NOT** give my permission for my child's **photo** to be displayed and published on the Field of Dreams website & Facebook page.

- ☐ I **DO NOT** give my permission for my child's **photo** to be taken at all.

Parent/Guardian Signature: _____ Date: _____
A copy will be filed in your child's folder.