Authorized Persons for Pick-Up

Child's Name: _____

Child's Date of Birth: _____

Center: _____

For safety reasons, BrightPath will only release a child to those individuals that have been designated by the child's parent(s) or legal guardian(s) as authorized to pick up the child. Legal counsel has informed us that unless a parent has secured an Order of Protection, both parents have equal rights to pick up the child. If an Order of Protection exists, BrightPath must be provided with an original copy of the Order. BrightPath must be informed of any individual(s) to whom the child **should not** be released.

The following person(s) are authorized to pick up my child:

	RELATIONSHIP	NAME	ADDRESS/PHONE
1.	Parent/Guardian		
2.	Parent/Guardian		
3.			
4.			
5.			
6.			
7.			
8.			

I understand that my child will only be released to the individuals I have listed above. I also understand that if my circumstances change, it is my responsibility to notify BrightPath and update the above list.

Parent Signature: _____

Date: _____

Door Code: _____

Approval of Policies

I have read, understand and agree to abide by the BrightPath policies, as put forth in the Parent Handbook and attached consent forms.

These policies include:

- Curriculum
- Hours/Sign-In Procedures
- Authorized Persons for Child Pick-Up
- Holiday/Snow Closings
- Absences
- Parent Involvement/Conferences
- Clothing Policy
- Electronics Policy
- Discipline Policy
- Field Trips
- Babysitting Policy
- Health Care Policies/Medical Release
- Prescription/Non-Prescription Medication Administration
- Nutrition and Food Allergy Policy
- Firearm Policy
- Child Abuse and/or Neglect Reporting
- Financial Policies/Agreement to Pay

_____ _____

Parent / Guardian Signature Date

_____ _____

Parent / Guardian Signature Date

Sleep/Rest Time Agreement

As an early care and education provider it is our responsibility to maintain a safe sleeping environment for your child. As per OCFS guidelines an agreement must be made outlining nap or rest time procedures for your child. **Please complete the form and return it to your Center Director. This agreement must be completed yearly.**
Thank You.

Sleep is an important part of healthy growth and development. When children sleep, their brains develop, they organize information, and they grow. Regular naps provide predictable routines and help children cope with the stimulating activities provided by the center.

Rest Schedule

Infants:

✓ In the infant rooms we provide opportunities for infants to nap as their individual schedule indicates. When infants are napping they are placed in an assigned crib and placed flat on their back to sleep, unless medical information from the child's health care provider is presented to the center, by the parent that states this arrangement is inappropriate for that child.

✓ Infant cribs may not have bumper pads, toys, large stuffed animals, heavy blankets, pillows, wedges, or infant positioners unless medical information from the child's health care provider is presented in writing indicating otherwise. In lieu of blankets, EduKids requires that parents provide "sleep sacks" ONLY for their infant.

Toddlers\ Preschool: 2 Hour Timeframe as per Classroom Schedule – Typically 1:00 PM – 3:00 PM

✓ Children 18 months and older will nap on a cot in the classroom. Rest time occurs from 1:00 PM-3:00 PM. The room is darkened, soothing music is played and backs will be rubbed if the child wishes. No child is ever forced to sleep, however, this is a quiet time and children are asked to rest quietly for a short time until those children needing to nap have settled. For those children who do not nap, they will be offered quiet activities; remembering that other children are sleeping.

✓ As children wake they will be allowed the same quiet activities. The staff will wake up all children with back rubbing, soft voices and kindness around 3:00 PM. Blankets will be put back in the child's cubby and children will be offered snack.

UPK Wrap Around Care: 2:00 PM - 3:00 PM (At select locations only)

✓ The UPK Extended Day/ Wrap Around children will be given the opportunity to nap from 2:00 PM-3:00 PM with the same rest time arrangement as our center children as stated above.

Supervision During Rest Time

As per the requirements specified in section 418-1.8 of the NYS OCFS Regulations, all children will have competent supervision by classroom staff during rest times. Children will be within a staff members range of vision, and will be close enough to assist a child who wakes from nap, or is playing quietly in the classroom. Please sign below indicating your understanding and agreement. If you have questions about this agreement or questions about your child's individual needs, please discuss this with the Center Director.

_____ _____

Parent Signature Date

_____ _____

Child's Name Classroom

Connect (Parent Engagement Program)

I _____ (Parent/Guardian Name) am the parent or guardian of _____ (Child's Name) (the "**child**") and have voluntarily chosen to participate in Connect (the "**Engagement Program**").

Participation Agreement

In consideration for BrightPath, its subsidiaries and affiliates (together "**BrightPath**") providing Connect (Engagement Program), accepting my application to participate in Connect Engagement Program, and providing me access to Connect (Engagement Program), I hereby understand, acknowledge, and agree that:

(a) Our participation in Connect (Engagement Program) is entirely voluntary and undertaken at my own and my child's risk.

(b) I have read the Connect Parent Engagement Information Letter attached hereto and I had all my questions in relation to Connect Engagement Program answered to my satisfaction prior to deciding to sign this Participation Agreement.

(d) I understand that I am prohibited from sharing photos and/or video of any children (other than my child), including any group photos/video, that I may have access to through my participation in the Connect Engagement Program. Should any photos and/or videos of children other than my child be distributed in violation of this covenant, I agree to indemnify and hold harmless BrightPath and its agents, employee, affiliates and/or assigns for all claims, liabilities, damages, losses and expenses (including legal fees on a solicitor and own client full indemnity basis) arising by reason of my unauthorized distribution in breach of this covenant.

(e) I understand and acknowledge that the Connect Engagement Program relies on the use of a third party provider (the "**Developer**") that utilizes the internet and cloud computing technology. Accordingly I acknowledge that the Developer will have access to information, photos and videos of and about my child and may create and hold electronic copies of this information for the purposes of back-up. The Developer may also monitor, for its internal use only, my access and use of the Connect Engagement Program. I understand and acknowledge that there are inherent privacy and confidentiality risks when using an internet-based service and cloud computing technology upon which the Connect Engagement Program relies. I understand and accept that BrightPath will have no liability in the event of any breach of confidentiality of any information collected and copied from the Connect

Engagement Program, whether or not such breach resulted from the actions of the Developer of BrightPath, its agents, employees, or assigns, or of any other parents who also participate in the Engagement Program. My participation in and use of the Connect Engagement Program is an acceptance of this limitation of liability.

(f) For greater certainly, I hereby release and forever discharge and agree not to make any claim against BrightPath, its board of directors, officers, agents, employees, affiliates and/or or assigns, for any and all claims, resulting from my participation and my child's participation in the Connect Engagement Program; and

(g) I understand and acknowledge that the terms of this waiver shall apply equally to me, and to my child.

Approval for Photos/Videos

I hereby grant permission to BrightPath and its representatives to photograph and video my child, and otherwise capture my child's image and to make recordings of my child's voice for the purposes of sharing information about my child with me under the Connect Parent Engagement Program.

I further grant permission to BrightPath and its representatives to reproduce, use, exhibit, display, post or distribute any images and recordings of my child when such images or recordings are taken in a group, or in a multiple child setting, to other parents who are also participating in the Connect Parent Engagement Program.

I hereby confirm and covenant that I will not share photos of any child (including group photos), other than my own, that I receive through the Connect Parent Engagement Program with anyone other than BrightPath and its employees.

I hereby release, defend, indemnify and hold harmless BrigthPath, employees or agents from and against any claims, damages or liability arising from or related to the use of images, recording or materials of my child, whether individually or in a group setting.

_____

(Name of Child)

_____ _____

(Parent/Guardian Signature) (Date)

_____ _____

(Witness) (Date)

Primary email: _____

Developmental History

Child's name:_____ Birth Date:_____

Who resides with your child in the home, in addition to his/her parents?

Name:_____ Relationship:_____ Birthdate:_____

Name:_____ Relationship:_____ Birthdate:_____

Name:_____ Relationship:_____ Birthdate:_____

Name:_____ Relationship:_____ Birthdate:_____

What is the primary language spoken in your home? _____

Personal History (Check all that apply)

Crawls☐ Walks☐ Talks☐ Speaks in Sentences☐

Special conditions or allergies?

Social History (Please check all that apply)

Plays well with others?☐ Prefers playing alone?☐ Naturally friendly?☐

Aggressive?☐ Shy?☐

What group contacts has your child had with other children?

Has your child ever attended any other child care program? Yes

If yes, please explain why you left:

What activities does your child particularly enjoy?

Fears: Animals?☐ Dark?☐ Storms?☐ Strangers?☐

Noise?☐ Others?_____

How do you comfort your child?

Self Help (Check all that apply)

Toileting habits Diapers? ☐ Pull ups? ☐ Training? ☐

Trained? ☐ Adult assistance needed? ☐ Cleans self? ☐

Frequent accidents? ☐ Occasional accidents? ☐

Special bathroom words? _____

Sleeping habits Blanket? ☐ Thumb? ☐ Animal? ☐

Pacifier? ☐ Bedtime _____ AM Wake time _____

How does your child sleep best? _____

Favorite foods? _____

Refused foods? _____

Special diet? _____

Does your child have any allergies, asthma, insect allergies, frequent ear infections, eye problems?

Does your child dress him/herself? _____

Indoor clothes? _____ Outdoor clothes? _____

Does child have any pets? _____ If so, please give name(s):

How is child disciplined at home?

What helps when your child is upset?

Do you have information that would help us better care for your child?

Please describe by approximate time, your child's current daily activities including nap and meal times?

Signature _____ **Date** _____

Parent or Guardian

Developmental History - Infant Supplement

Child's Name:

Birth Date: Birth Weight:

Birth Place: Current Weight:

Were there complications during pregnancy or at birth? Yes

If yes, please describe:

Did you bring your baby home from the hospital with you? Yes

If not, please briefly describe why:

Is your infant nursing, formula fed or supplemented with bottles? Nursing

Name of Formula used:

Please clearly describe feedings:

Feeding Schedule - Please indicate exact amounts of formula/breast milk needed at each feeding along with any cereal or baby food/table food:

Please describe in detail your infants "rhythms" of the day including awake times, "fussy" periods, naps and rest periods, play times and how often you typically stimulate your baby through toys and music.

Does your child...

Sleep through the night:

Self sooth:

Settle when held, worn in a sling/baby carrier, etc:

Turn their head:

Sit in a bouncy seat:

Burp after feedings:

Use a pacifier:

Suck their thumb:

Sit in a swing:

Engage in/Enjoy tummy time:

Who does your child live with? Please list the names of all persons living in your household. Be sure to include the names and ages of all siblings:

Does your child have any allergies or suspected allergies? If yes, please describe in detail:

What else would you like us to know about your little one or your family?:

We encourage parents to try new foods with children at home before we introduce them at BrightPath in case of allergies or food sensitivities. Once children have moved to table food, consistently, parents will be provided with our rotating menu from their center. If your child is currently on table food, please circle and date the items (on the menu) that you give permission to serve to your child for lunch as well as for AM/PM snack.

Infant Feeding Agreement

As an early care and education provider, it is our responsibility to maintain a safe classroom environment for your child. As per OCFS guidelines, an agreement must be made outlining feeding procedures for your child. Please review the following statements, sign, and return it to your Center Director.

- A schedule of your child's feeding/drinking routine must be provided by the family and updated as needed including times and types of fluids/foods offered. Template attached.
- All containers or bottles of breast milk, formula or other individualized food items must be provided by family and clearly marked with the child's complete name.
- Bottles should be prepared and provided by the family each day. Designated staff members may prepare formula when agreed to in writing by the parent.
- Unused portions of bottles or containers from which children have eaten must be discarded after each feeding or placed in a securely tied bag and returned to parent at the end of the day. Please let us know your preference.
- Bottles and food items will be warmed using hot water. Microwave use is prohibited.
- Every effort will be made to accommodate the needs of a child who is being breast fed. If you wish to visit the center to breast feed, please let your Center Director know so that private space is made available.
- Infants six months of age or younger will be held while being bottle fed. Infants older than six months will be held until the infant consistently demonstrates the capability of holding the bottle and ingesting an adequate portion of the contents. At that point, infants may sit in a highchair with their bottle.
- Age-appropriate solid foods will be introduced in consultation with families.
- Current menus for each week will be available on parent boards as well as in the parent communication app.

Please sign below indicating your understanding and agreement. If you have questions about this agreement or questions about your child's individual needs, please discuss this with the Center Director.

_____ _____

Parent Signature Date

_____ _____

Child's Name Classroom

Infant Feeding Schedule

Child's Name: Date of Birth:

Fluids

Please select type of fluids:

☐ Breast Milk ☐ Formula (brand:) ☐ Milk

Initial here to give staff permission to prepare bottles: _____

Please list times and amount for bottles to be given:

Foods

Please list times, types, and amounts of solids to be given (jar food, baby cereal, finger foods, etc.):

Allergies and Special Instructions

Please list any known allergies, food intolerances, restrictions or special instructions regarding your child's eating habits:

Parent signature _____ Date _____

OCFS-6010 (5/2015)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

NON-MEDICATION CONSENT FORM

Child Day Care Programs

- This form may be used when a parent consents to having over-the-counter products administered to their child in a child day care program. These products include, but are not limited to: topical ointments, lotions and creams, sprays, sunscreen products and topically applied insect repellant.
- This form should NOT be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays. OCFS Form 7002 would meet the consent requirements for medications.
- One form must be completed for each over-the-counter product. Multiple products cannot be listed on one form.
- This form must be completed in a language in which the staff is literate.
- If parent's instructions differ from the instructions on the product's packaging, permission must be received from a health care provider or licensed authorized prescriber.

PARENT TO COMPLETE THIS SECTION (#1 - #14)

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:

4. Name of product (including strength):	5. Amount to be administered:	6. Route of administration:

7A. Frequency to be administered, include times of day if appropriate: _____

OR

7B. Identify the conditions that will necessitate administration of the product (signs and symptoms must be observable prior to administration): _____

8A. Possible side effects: ☐ See product label for complete list of possible side effects (parent must supply)

AND/OR

8B: Additional side effects: _____

9. What action should the child care provider take if side effects are noted:

☐ Contact parent _____

Other (describe): _____

10A. Special instructions: ☐ See package insert for complete list of special instructions (parent must supply)

AND/OR

10B. Additional special instructions: _____

11. Reason(s) for use (unless confidential by law):

12. Parent name (please print):	13. Date authorized:

14. Parent signature:

X

DAY CARE PROGRAM TO COMPLETE THIS SECTION (#15 - #21)

15. Program name:	16. Faciity ID number:	17. Program telephone number:
BrightPath		

18. I have verified that #1, -#14 are complete. My signature indicates that all information needed to administer this product has been given to the child day care program.

19. Staff's name (please print):	20. Date received from parent:
Cindy Del Valle	

21. Staff's signature:

X

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

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICATION CONSENT FORM

CHILD DAY CARE PROGRAMS

- This form may be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays.
- Only those staff certified to administer medications to day care children are permitted to do so.
- One form must be completed for each medication. Multiple medications cannot be listed on one form.
- Consent forms must be reauthorized at least once every six months for children under 5 years of age and at least once every 12 months for children 5 years of age and older.

LICENSED AUTHORIZED PRESCRIBER COMPLETE THIS SECTION (#1 - #18) AND AS NEEDED (#33 - 35).

1. Child's First and Last Name:	2. Date of Birth: / /	3. Child's Known Allergies:
4. Name of Medication *(including strength):*	5. Amount/Dosage to be Given:	6. Route of Administration:

7A. Frequency to be administered: _____

OR

7B. Identify the symptoms that will necessitate administration of medication: *(signs and symptoms must be observable and, when possible, measurable parameters)*: _____

8A. Possible side effects: ☐ See package insert for complete list of possible side effects *(parent must supply)*

AND/OR

8B: Additional side effects:

9. What action should the child care provider take if side effects are noted:

☐ Contact parent ☐ Contact health care provider at phone number provided below

☐ Other *(describe):* _____

10A. Special instructions: ☐ See package insert for complete list of special instructions *(parent must supply)*

AND/OR

10B. Additional special instructions: *(Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situation's when medication should not be administered.)* _____

11. Reason for medication *(unless confidential by law)*: _____

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and requires health and related services of a type or amount beyond that required by children generally?

☐ No ☐ Yes If you checked yes, complete (#33 and #35) on the back of this form.

13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered?

☐ No ☐ Yes If you checked yes, complete (#34 -#35) on the back of this form.

14. Date Health Care Provider Authorized: / /	15. Date to be Discontinued or Length of Time in Days to be Given: / /
16. Licensed Authorized Prescriber's Name (please print):	17. Licensed Authorized Prescriber's Telephone Number:

18. Licensed Authorized Prescriber's Signature:

X

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICATION CONSENT FORM

CHILD DAY CARE PROGRAMS

PARENT COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? *(For example, did the licensed authorized prescriber write 12pm?)* ☐ Yes ☐ N/A ☐ No

Write the specific time(s) the child day care program is to administer the medication *(i.e.: 12 pm)*: _____

20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to *(child's name):*

21. Parent's Name *(please print)*:	22. Date Authorized: / /

23. Parent's Signature:

X

CHILD DAY CARE PROGRAM COMPLETE THIS SECTION (#24 - #30)

24. Program Name:	25. Facility ID Number:	26. Program Telephone Number:

27. I have verified that (#1 - #23) and if applicable,(#33 - #36) are complete. My signature indicates that all information needed to give this medication has been given to the day care program.

28. Staff's Name *(please print)*:	29. Date Received from Parent: / /

30. Staff Signature:

X

ONLY COMPLETE THIS SECTION (#31 - #32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN (#15)

31. I, parent, request that the medication indicated on this consent form be discontinued on **/ /**
(Date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent Signature:

X

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #35)

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.

34. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date you are ordering the change in the administration of the prescription to take place.

DATE: / / _____

By completing this section, the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

35. Licensed Authorized Prescriber's Signature:

X

NEW YORK STATE DEPARTMENT OF HEALTH
Child and Adult Care Food Program

Income Eligibility Form for Child Care Centers

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME _____

Print the name of the child(ren) enrolled in this child care center

1. _____ 2. _____ 3. _____

Complete SECTION A if anyone in your household

1. Participates in the Supplemental Nutrition Assistance Program (SNAP)
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR) OR
4. Is a foster child

SECTION A

SNAP Case # _____

TANF # _____

FDPIR # _____

Names of Foster Children

_____

_____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true. I understand that the center will get Federal funds based on the information I give.

Signature _____

Date _____

FOR THE CHILDCARE CENTER TO COMPLETE

CACFP Agreement # _____

Total Number of Household Members _____
(INCLUDING FOSTER CHILDREN, IF APPLICABLE)

Total Household Income $ _____

Free _____ Reduced _____ Paid _____

Date of Determination _____

Signature of
Center Staff _____

Complete SECTION B if no one in your household participates in SNAP, receives TANF, participates in FDPIR or if none of the children enrolled in the child care center is a foster child.

SECTION B

List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received **last month** in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, child support, foster child's personal income and any other sources of income.

HOUSEHOLD MEMBER NAME	MONTHLY GROSS SALARY
1. _____	$ _____
2. _____	$ _____
3. _____	$ _____
4. _____	$ _____
5. _____	$ _____
6. _____	$ _____
7. _____	$ _____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true and that all income is reported. I understand that the center will receive Federal funds based on the information I give.

Signature _____

Print Name _____

LAST FOUR (4) DIGITS OF SOCIAL SECURITY NUMBER | | | | |

Date _____

This institution is an equal opportunity provider.

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this form. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the form. The Social Security Number is not required when you: apply on behalf of a foster child; provide a SNAP, TANF or FDPIR number; or when you indicate that the adult household member signing the form does not have a Social Security Number. We will use your information to determine if the center is eligible for free or reduced-price meal reimbursement and for administration and enforcement of the Program.

INSTRUCTIONS FOR COMPLETING DOH-3688

Definition of Income

Income means income before deductions for income taxes, social security taxes, insurance premiums, charitable contributions, and bonds, etc. It includes the following: (1) monetary compensation for services, including wages, salary, commissions or fees; (2) net income from non-farm self-employment; (3) net income from farm self-employment; (4) Social Security payments; (5) dividends or interest on savings or bonds, income from estates or trusts or net rental income; (6) unemployment compensation; (7) government civilian employee or military retirement, or pensions or veteran's payments; (8) private pensions or annuities; (9) alimony or child support payments; (10) regular contributions from persons not living in the household; (11) net royalties; (12) military benefits received in cash, such as housing allowance except if you are in the Military Housing Privatization Initiative; and (13) any other cash income.

Definition of Household

Household means *family* as defined in 7 CRF 22.6.2. *Family* means a group of related or unrelated individuals who are not residents of an institution or boarding house, but who are living as one economic unit.

INSTRUCTIONS FOR PARENTS OR GUARDIANS

Write in the name of the child care center in the space provided.

Print the name of each child in your household who attends this child care center.

Section A: If anyone in your household participates in the Supplemental Nutrition Assistance Program (SNAP), receives Temporary Assistance for Needy Families (TANF) or participates in the Food Distribution Program on Indian Reservations (FDPIR), complete Section A only. Write down the SNAP, TANF or FDPIR number (do not use your ACS or DSS child care subsidy number). Then sign and date the form and return it to the day care center.

Foster children: If your household includes a foster child who is in child care, write in the names of the foster children.

Section B: Complete this section if you did not complete Section A. Write in your name and the names of all other adults and children living in the household, including unrelated people, even if they do not have any income. Do not include the children in child care who are listed at the top of the form.

Enter the amount of income each person received **last month**, before taxes or anything else was taken out. Refer to the Definition of Income and the Definition of Household, above. If any amount last month was more or less than the usual, write in that person's usual income.

The last four digits of the Social Security Number of the adult signing the certification is required. If you do not have a Social Security Number, write *none*. The form must be signed by an adult member of the household.

INSTRUCTIONS FOR SPONSORS AND CENTERS

The *For The Childcare Center To Complete* section is to be completed, signed and dated by sponsor or center staff. The sponsor/center representative must review the income eligibility form and ensure that it is completed as indicated in the instructions above. Then indicate the following:

The CACFP Agreement Number.

Total Number of Household Members – This item does not have to be completed if the parent completed Section A. Add those indicated in Section B (if completed) to the children enrolled in child care and the number of foster children, if applicable.

Total Household Income – This item does not need to be completed if the parent completed Section A. Indicate the total monthly income as calculated from Section B. If the parent chooses not to disclose income, the form must be categorized as *paid*.

Number of Free, Reduced or Paid – Compare the total household income and the total number of household members with the current year's Income Eligibility Guidelines (CACFP-3687) to determine if the household should be categorized as **Free, Reduced or Paid**. Use the appropriate column on the CACFP-3687 to categorize their income. For example, if the parent indicated biweekly income, multiply this amount by 26 to determine yearly income.

Incomplete forms (missing signatures, income information, last four digits of Social Security Number or SNAP, TANF or FDPIR numbers) are categorized in the paid category.

The income eligibility form is valid until the last day of the month one calendar year from the date it is signed by the household member. For example, a form signed on May 12, 2023 is valid until May 31, 2024.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
INDIVIDUAL ALLERGY AND ANAPHYLAXIS EMERGENCY PLAN

Instructions:

- This form is to be completed for any child with a known allergy.
- The child care program must work with the parent(s)/guardian(s) and the child's health care provider to develop written instructions outlining what the child is allergic to and the prevention strategies and steps that must be taken if the child is exposed to a known allergen or is showing symptoms of exposure.
- This plan must be reviewed upon admission, annually thereafter, and anytime there are staff or volunteer changes, and/or anytime information regarding the child's allergy or treatment changes. This document must be attached to the child's Individual Health Care Plan.
- Add additional sheets if additional documentation or instruction is necessary.

Child's Name: Date of Plan: / /
Date of Birth: / / Current Weight: lbs.
Asthma: ☐ Yes (higher risk for reaction) ☐ No

My child is reactive to the following allergens:

Allergen:	**Type of Exposure**: (***i.e.**, air/skin contact/ingestion, etc.*):	**Symptoms include but are not limited to:** (***check all that apply***)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)

If my child was LIKELY exposed to an allergen, for ANY symptoms:
☐ give epinephrine immediately

If my child was DEFINITELY exposed to an allergen, even if no symptoms are present:
☐ give epinephrine immediately

Date of Plan: / /

THE FOLLOWING STEPS WILL BE TAKEN IF THE CHILD EXHIBITS SYMPTOMS including, but not limited to:

- **Inject epinephrine immediately and note the time when the first dose is given**.
- **Call 911/local rescue squad** (Advise 911 the child is in anaphylaxis and may need epinephrine when emergency responders arrive).
- Lay the person flat, raise legs, and keep warm. If breathing is difficult or the child is vomiting, allow them to sit up or lie on their side.
- If symptoms do not improve, or symptoms return, an additional dose of epinephrine can be given in consultation with 911/emergency medical technicians.
- Alert the child's parents/guardians and emergency contacts.
- After the needs of the child and all others in care have been met, immediately notify the office.

MEDICATION/DOSES

- Epinephrine brand or generic:
- Epinephrine dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

ADMINISTRATION AND SAFETY INFORMATION FOR EPINEPHRINE AUTO-INJECTORS

When administering an epinephrine auto-injector follow these guidelines:

- Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than the mid-outer thigh. If a staff member is accidentally injected, they should seek medical attention at the nearest emergency room.
- If administering an auto-injector to a young child, hold their leg firmly in place before and during injection to prevent injuries.
- Epinephrine can be injected through clothing if needed.
- Call 911 immediately after injection.

STORAGE OF EPINEPHRINE AUTO-INJECTORS

- All medication will be kept in its original labeled container.
- Medication must be kept in a clean area that is inaccessible to children.
- All staff must have an awareness of where the child's medication is stored.
- Note any medications, such as epinephrine auto-injectors, that may be stored in a different area.
- Explain here where medication will be stored:

MAT/EMAT CERTIFIED PROGRAMS ONLY

Only staff listed in the program's Health Care Plan as medication administrant(s) can administer the following medications. Staff must be at least 18 years old and have first aid and CPR certificates that cover all ages of children in care.

- Antihistamine brand or generic:
- Antihistamine dose:
- Other (e.g., inhaler-bronchodilator if wheezing):

***Note: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

STORAGE OF INHALERS, ANTIHISTAMINES, BRONCHODILATOR

All medication will be kept in its original labeled container. Medication must be kept in a clean area that is inaccessible to children. All staff must have an awareness of where the child's medication is stored. Explain where medication will be stored. Note any medications, such as asthma inhalers, that may be stored in a different area.

Explain here:

STRATEGIES TO REDUCE THE RISK OF EXPOSURE TO ALLERGIC TRIGGERS

The following strategies will be taken by the child care program to minimize the risk of exposure to any allergens while the above-named child is in care (add additional sheets if needed):

Document plan here:

EMERGENCY CONTACTS – CALL 911	
Ambulance: ( ) -	
Child's Health Care Provider:	Phone #: ( ) -
Parent/Guardian:	Phone #: ( ) -
CHILD'S EMERGENCY CONTACTS	
Name/Relationship:	Phone#: ( ) -
Name/Relationship:	Phone#: ( ) -
Name/Relationship:	Phone#: ( ) -

Parent/Guardian Authorization Signature:	Date: / /
Physician/HCP Authorization Signature:	Date: / /
Program Authorization Signature:	Date: / /

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: / /

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: / /

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICATION CONSENT FORM

CHILD DAY CARE PROGRAMS

- This form may be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays.
- Only those staff certified to administer medications to day care children are permitted to do so.
- One form must be completed for each medication. Multiple medications cannot be listed on one form.
- Consent forms must be reauthorized at least once every six months for children under 5 years of age and at least once every 12 months for children 5 years of age and older.

LICENSED AUTHORIZED PRESCRIBER COMPLETE THIS SECTION (#1 - #18) AND AS NEEDED (#33 - 35).

1. Child's First and Last Name:	2. Date of Birth: / /	3. Child's Known Allergies:
4. Name of Medication *(including strength):*	5. Amount/Dosage to be Given:	6. Route of Administration:

7A. Frequency to be administered: _____

OR

7B. Identify the symptoms that will necessitate administration of medication: *(signs and symptoms must be observable and, when possible, measurable parameters)*: _____

8A. Possible side effects: ☐ See package insert for complete list of possible side effects *(parent must supply)*

AND/OR

8B: Additional side effects:

9. What action should the child care provider take if side effects are noted:

☐ Contact parent ☐ Contact health care provider at phone number provided below

☐ Other *(describe):* _____

10A. Special instructions: ☐ See package insert for complete list of special instructions *(parent must supply)*

AND/OR

10B. Additional special instructions: *(Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situation's when medication should not be administered.)* _____

11. Reason for medication *(unless confidential by law)*: _____

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and requires health and related services of a type or amount beyond that required by children generally?

☐ No ☐ Yes If you checked yes, complete (#33 and #35) on the back of this form.

13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered?

☐ No ☐ Yes If you checked yes, complete (#34 -#35) on the back of this form.

14. Date Health Care Provider Authorized: / /	15. Date to be Discontinued or Length of Time in Days to be Given: / /
16. Licensed Authorized Prescriber's Name (please print):	17. Licensed Authorized Prescriber's Telephone Number:

18. Licensed Authorized Prescriber's Signature:

X

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICATION CONSENT FORM

CHILD DAY CARE PROGRAMS

PARENT COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? *(For example, did the licensed authorized prescriber write 12pm?)* ☐ Yes ☐ N/A ☐ No

Write the specific time(s) the child day care program is to administer the medication *(i.e.: 12 pm)*: _____

20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to *(child's name):*

21. Parent's Name *(please print)*:	22. Date Authorized: / /

23. Parent's Signature:

X

CHILD DAY CARE PROGRAM COMPLETE THIS SECTION (#24 - #30)

24. Program Name:	25. Facility ID Number:	26. Program Telephone Number:

27. I have verified that (#1 - #23) and if applicable,(#33 - #36) are complete. My signature indicates that all information needed to give this medication has been given to the day care program.

28. Staff's Name *(please print)*:	29. Date Received from Parent: / /

30. Staff Signature:

X

ONLY COMPLETE THIS SECTION (#31 - #32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN (#15)

31. I, parent, request that the medication indicated on this consent form be discontinued on **/ /**
(Date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent Signature:

X

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #35)

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.

34. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date you are ordering the change in the administration of the prescription to take place.

DATE: / / _____

By completing this section, the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

35. Licensed Authorized Prescriber's Signature:

X