

Sweet Angels Daycare and Preschool

Child Care Enrollment Form

Child's Full Name: _____ Address: _____ City: _____ State: <u>New York</u>	Birth Date: _____ Home Phone: _____ Zip: _____
Mother's Full Name: _____ Address: _____ City: _____ State: <u>New York</u>	Home Phone: _____ Zip: _____ Work Phone: _____ Ext. _____ Cell Phone: _____
Name of Employer: _____ Business Address: _____ Work Hours: _____	Work Phone: _____ Ext. _____ Cell Phone: _____
Father's Full Name: _____ Address: _____ City: _____ State: <u>New York</u>	Home Phone: _____ Zip: _____ Work Phone: _____ Ext. _____ Cell Phone: _____
Name of Employer: _____ Business Address: _____ Work Hours: _____	Work Phone: _____ Ext. _____ Cell Phone: _____
Guardian Other Than Above/ Full Name: _____ Home Phone: _____ Address: _____ City: _____ State: <u>New York</u>	
Zip: _____ Name of Employer: _____ Business Address: _____ Work Hours: _____	
Work Phone: _____ Ext. _____ Cell Phone: _____	
Parent or Guardian with legal custody: _____ Parents are: Married _____ Divorced: _____ Separated: _____ Widowed: _____ Single: _____	
Primary Emergency Contact (other than parents or guardian): _____ Home Phone: _____ Work Phone: _____ Relationship to Child: _____ Address: _____	
Secondary Emergency Contact (other than parents or guardian): _____ Home Phone: _____ Work Phone: _____ Relationship to Child: _____ Address: _____	

PLEASE FILL OUT.....

PHONE NUMBER I WISH FOR MESSAGES TO BE SENT

NAME.... _____ NUMBER... _____
 NAME.... _____ NUMBER... _____

Emergency Transportation and Treatment Agreement

Fill out either section 1 OR 2 below. DO NOT fill out both

1. Permission to transport and secure Treatment:

In the event that I can not be reached to make arrangement for emergency medical or dental care for my child, I grant permission for:

(Name of child care provider or facility)

to take my child:

(Name of child)

to the nearest hospital or medical or dental facility for treatment for any accident or illness as deemed necessary by the provider. I accept liability for all treatment and ambulance expenses.

Signature:

(Signature of parent or Guardian, and date)

2. Refusal to Grant Permission:

In the event that I cannot be reached to make arrangements for emergency medical or dental care for my child,
I **DO NOT** grant my permission for:

(Name of child care provider or facility)

to take my child:

(Name of child)

to the nearest hospital or medical or dental facility for treatment for any accident or illness as deemed necessary by the provider.

Instead, I wish the following action to be taken:

Signature:

(Signature of parent or guardian, and date)

ILLNESS POLICY

I, _____ have read the following chart and understand that if my child develops any of the following illnesses that my child, _____ cannot return to daycare until the listed criteria are fully met.

Parent/Guardian Signature: _____ Date: _____

ILLNESS	SYMPTOMS	DISMISSAL FROM DAYCARE	CAN RETURN TO DAYCARE WHEN...
FEVER	FEVER 101 OR HIGHER	YES	MUST BE FEVER FREE FULL 24 HOURS WITHOUT RECEIVING MEDICATION, UNLESS DOCTOR NOTE IS OBTAINED
FEVER	FEVER 99-100.9	WILL BE DETERMINED CASE BY CASE	WHEN FEELING WELL, MUST BE ABLE TO PARTICIPATE IN NORMAL ACTIVITIES
ROSEOLA	3-4 DAYS OF FEVER, RASH AFTER FEVER BREAKS	YES	WHEN FEELING WELL, MUST BE ABLE TO PARTICIPATE IN NORMAL ACTIVITIES,
IMPETIGO	SKIN SORES WITH YELLOWISH CRUSTS, OOZY RED/ROUND RASH, CAN BE FLAT HONEY/RUST COLORED	YES	FULL 24 HOURS AFTER ANTIBIOTIC STARTED
LICE	VISIBLE NITS OR LICE	YES	72 HOURS AFTER TREATMENT IS COMPLETED
PINK EYE	WHITES OF EYE APPEAR PINK OR RED. WHITE, YELLOW OR GREEN DISCHARGE FROM EYE	YES	FULL 24 HOURS AFTER ANTIBIOTIC STARTED
COLD	SNEEZING, COUGH, RUNNY NOSE, SORE THROAT	WILL BE DETERMINED CASE BY CASE	WHEN FEELING WELL, MUST BE ABLE TO PARTICIPATE IN NORMAL ACTIVITIES
COUGH	UNCONTROLLED COUGH THAT PREVENTS YOUR CHILD FROM EATING, SLEEPING, OR PERFORMING NORMAL DAILY ACTIVITIES	WILL BE DETERMINED CASE BY CASE	WHEN FEELING WELL, MUST BE ABLE TO PARTICIPATE IN NORMAL ACTIVITIES
DIARRHEA	INCREASE IN NUMBER OF STOOLS OVER WHAT IS NORMAL FOR PARTICULAR CHILD, STOOL IS LOOSE AND WATERY	YES- IF UNCONTROLLED DIARRHEA- STOOL RUNS OUT OF DIAPER, CHILD CAN'T GET TO THE TOILET IN TIME, OR 3 OR MORE BOUTS OF DIARRHEA IN ONE DAY	WHEN STOOLS RETURN TO NORMAL FOR FULL 24 HOURS
RING WORM	SCALY ROUND RASH	YES	FULL 24 HOURS AFTER TREATMENT HAS BEEN STARTED
SCABIES	ITCHY BUMPS THAT ARE SKIN MITES	YES	48 HOURS AFTER TREATMENT HAS BEEN STARTED
STREP THROAT	FEVER, TENDER SWOLLEN GLANDS, SORE THROAT, HEADACHE, STOMACHE	YES	FULL 24 HOURS AFTER ANTIBIOTIC HAS BEEN STARTED
VOMITING	CHILD VOMITS WHILE AT DAYCARE, OR 24 HOURS PRIOR TO ATTENDING DAYCARE	YES	CAN RETURN WHEN HE/SHE HAS NOT VOMITED IN THE PREVIOUS 24 HOURS
SHORTNESS OF BREATH- NOT ASTHMA RELATED	SUCKING IN OF CHEST MUSCLES, FASTER THAN NORMAL BREATHING EVEN WHEN CHILD IS CALM, COLOR CHANGES AROUND MOUTH, FACE, FINGERS TO GREYISH/BLUISH COLOR	YES	WITH A DOCTOR'S NOTE
SHORTNESS OF BREATH- DUE TO ASTHMA	WHEEZING OR WHISTLING SOUND WHEN BREATHING, COUGHING, CHEST CONGESTION OR TIGHTNESS	YES- IF ON HAND MEDICATION IS NOT WORKING	WHEN BREATH HAS BEEN CONTROLLED
UNEXPLAINED RASH	ANY RASH SYMPTOMS NOT EXPLAINED, ONE THAT SPREADS OVER TIME OR IS WIDESPREAD	YES	WITH A DOCTOR'S NOTE
HAND FOOT MOUTH DISEASE	DEHYDRATION, MALAISE, LOSS OF APPETITE, FEVER, SORE OR RED SPOTS INSIDE MOUTH, HANDS OR FEET	YES	WITH A DOCTOR'S NOTE AND CAN RETURN ONCE FEVER FREE FOR FULL 24 HOURS WITHOUT FEVER REDUCING MEDICATION, AND MOUTH LESIONS ARE RESOLVED, AND CHILD CAN EAT AND DRINK NORMALLY. CHILD WITH OTHER LESIONS THAT CANNOT BE COVERED WILL BE EXCLUDED UNTIL DRIED UP.
CROUP	COUGH, DIFFICULTY BREATHING, FAST/NOISY BREATHING, SHORTNESS OF BREATH, WHEEZING, RUNNY NOSE, PHELGM, SORE THROAT	YES	CAN RETURN 3 FULL DAYS AFTER ILLNESS BEGINS AND FEVER FREE FOR 24 HOURS
THRUSH	WHITE PATCHES IN MOUTH, ON TONGUE/LIPS THAT LOOK LIKE COTTAGE CHEESE, SORE MOUTH/TONGUE, DIFFICULTY SWALLOWING, POOR APPETITE, DIAPER RASH	YES	AFTER ONE TREATMENT, AS LONG AS CHILD CAN EAT, DRINK AND PARTICIPATE IN NORMAL ACTIVITIES

Field Trip Permission Slip



I, _____ give permission for Sweet Angels Daycare & Preschool to take my child _____ on field trips.

A form will be placed in my child's file and I understand that I also need to sign a field trip form that will be given to me prior to the scheduled trip. My child needs to have consistent inappropriate behavior he/she may not be allowed to participate in field trips, as it may jeopardize the safety of the other children. Field trips are an earned privilege, it may be necessary to take away privileges as consequences of a child's actions. I understand I may need to make other arrangements for my child that day.

Signature _____ Date _____

I will be notified 1 week in advance to the nature and cost, if any, of the field trip.



All About Form

Full Name: _____ Date of Birth: _____
Gender: _____

Has or does your child have any known health problems? Yes () No () If yes, please describe:

Does your child need regular medication for health problems? Yes () No () If yes, what and when is it given?

Any allergies? Yes () No () If yes, please list allergies:

Special instructions in the event of an allergic reaction?

Please check any of the following communicable diseases your child has had:

- Chicken Pox ()
- German Measles Mumps ()
- Scarlet Fever ()
- Ringworm ()
- Tuberculosis ()
- Polio ()
- Hepatitis ()
- Other (please list):

Please check any of the following that your child may be prone to:

- Stomach Upsets ()
- Colds ()
- Bronchitis ()
- Asthma ()
- Whooping Cough ()
- Headaches ()
- Skin Rashes ()
- Urinary Problems ()
- Sore Throat ()
- Ear Aches ()
- Ear Infections ()
- Diabetes ()
- Convulsions ()
- Heart Trouble ()
- Fainting Spells ()
- Other (please list):

Has your child has any recent serious illness? If Yes, please describe:

Are there any indications of vision or hearing problems? If yes, please describe:

Does your child have any mental or physical disabilities? If yes, please describe:

Do you have a back up plan if your child is ill and cannot attend daycare? Yes() No()

Child's usual dining habits (check all that apply):

- Bottle ()
- Sippy Cup ()
- Regular Cup ()
- Highchair ()
- Table ()
- Uses Fingers ()
- Uses Utensils ()
- If your child is on a bottle, what kind on formula does he/she use?

How much and how often?

What type of bottle and nipple do you use?

Does your child have a large or small appetite?

Favorite Foods:

Strong Dislikes:

Are there any particular foods that you do not want your child to have due to religious beliefs?

Please briefly describe your child's personality:

Is your child comfortable with other adults?

Is your child comfortable with other children?

How does your child act when left with someone other than family member or close friend?

How does your child show anger?

How does your child show he/she is afraid?

Are there any special family situations we should be aware of (such as custody, guardianship, problems arising from them, etc.)? If yes, please explain:

Do you have any problem with your child celebrating any holidays? If yes, please list:

What is your child's favorite indoor activity?

What is your child's favorite outdoor activity?

What is your child's favorite toy?

Does your child normally nap at home and if so what is the normal nap schedule...

Does child have a special toy or "lovely" for nap time? Yes () No ()

Is your child potty trained? Yes () No ()

If yes, what words does your child use for the use of the bathroom?

How much help does your child need in the bathroom?

Does your child have accidents, and if yes, approximately how often?

What are your expectations of Sweet Angels Daycare?

Is there anything else you feel we should know in order for us to better care for your child?

Thank you for taking the time to fill this form out on your child. The purpose of this form is to get to know your child better and to understand their wants and needs as an individual. From all of us at Sweet Angels we look forward to caring for your child.

Permission to Photograph

I, _____ give permission for Sweet Angels Daycare & Preschool to
 (Parent's or Guardian's name)

photograph my child, _____ for the following purposes:
 (Child's name)

Type of Use:	Please check one	
	Grant	Decline
Display in provider's personal scrapbook		
Give photographs to current clients		
Display in facility's scrapbook or bulletin boards, shown to current and prospective clients		
Display still photo's on facility's website		
Use still photos in promotional materials		
Give video to current parents		
Display video on facility website		
Use videos in promotional materials		
Use on CLOSED Facebook page		
Place picture in cubby		
Place pictures in Newsletter		

Only first names and possibly last initials (in the event that two or more children with the same first name) will be displayed on the facility website.

I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

Signed: _____
 (Parent or Guardian signature, and date)

Parent Handbook Acknowledgment

The following is an agreement between _____, parent(s), and Sweet Angels Daycare & Preschool regarding the care of _____, birth date _____.

A ONE TIME registration, non - refundable fee of \$35.00 is required when registering child. Also a one week Deposit equal to one week of care is due upon initial enrollment. This fee will be credited toward the child's last week of care.

Child care will be provided:

___ Monday ___ Tuesday ___ Wednesday ___ Thursday ___ Friday

between the hours of ___ and ___.

My child will be attending: ___ Gymnastics every Tuesday ___ Yoga every Friday

I understand there is an additional \$7.00 per class every week that will be added to my tuition.

My weekly tuition payment will be \$ _____. Convenience fee is added if paying with a credit card

Breakfast is served between 8:00am to 8:30am. Lunch is served between 11:30am to 12:00pm. Afternoon snack is served between 2:30pm to 4:30pm. If your child is here during these times they will receive these meals.

My child is present for the following meals:

___ Breakfast ___ Lunch ___ Afternoon Snack

Tuition is due every Friday prior to your child's week of care. I understand that a late fee of \$10.00 per day will be assessed to my account if payment is not received by 6pm on Friday or if my child is not picked up by the contracted time.

I/We have read and do understand and agree to abide with all policies and procedures as described in the "Parent Handbook." I/We also understand that Sweet Angels Daycare & Preschool, providing 30 days notice to me/us, may change the contents of this handbook at any time. I have received a copy of this handbook.

Mother's Signature: _____ **Date** _____

Father's Signature: _____ **Date** _____

Guardian's Signature: _____ **Date** _____

PARENT CONTRACT- COMPLETE ONLY IF RECEIVING TUITION ASSISTANCE FROM SOCIAL SERVICES

If you receive daycare payment assistance through Niagara OR Erie County please complete the contract below:

I, _____ understand and agree to the following:

I understand I am only allotted 30 minutes of travel time before my start time at work. This means I can drop off no more than 30 minutes prior to my start time.

I understand that I am only allotted 30 minutes of travel time after my end time at work. This means I must pick up no more than 30 minutes after my end time at work.

I understand that I must turn in weekly or biweekly paystubs to the center. I understand that the hours I am paid on my paystubs must coincide with the number of hours my child/children are at the center.

I understand that if I need my child/children to arrive earlier than my scheduled time, or stay later than my scheduled time I must get prior approval and make payment for the additional time in advance of drop off or at pickup time.

I understand that if both legal parents/guardians are living in the same household with my children, I must also submit signed punch in/punch out times for both parents/guardians that covers the days/times my child/children were in daycare.

I understand that when both parents/guardians are living in the same household, daycare assistance will not cover or pay for any times that do not overlap.

I understand that failure to provide paystubs and punch in/out times that cover days/times my child attended can result in a suspension/termination of daycare services.

I understand that copays are due on the Friday before care is provided for the following week. I understand that failure to make this payment can result in suspension of daycare services.

Children's name/names: _____ My copay per week is: _____

Convenience Fee is added if paying with a credit card

My work hours are as follows:

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Signature: _____

Date: _____

VACATION/SICK TIME POLICY AGREEMENT

I, _____ understand the following policy regarding vacation/sick time.

Each child in care will be allowed two weeks of vacation/sick time annually equal to two weeks of care in the center. Notice is greatly appreciated. A child must be enrolled for at least 90 days prior to using vacation/sick time. Twelve months following the child's enrollment date vacation/sick time will be automatically renewed. If a Vacation/Sick day is taken before the 90 day period a Fee of 1/2 the normal daily fee will be charged per day. **You are responsible to pay for your child's regular scheduled days once all vacation/sick time has been used until the anniversary date, regardless of the notice given.** Adjustments to vacation/sick time will be made based on changes to your child's permanent schedule.

NUMBER OF DAYS ATTENDED, AS PER SIGNED CONTRACT	VACATION/SICK DAYS ALLOTTED
1 DAY	2 DAYS PER YEAR
2 DAYS PER WEEK	4 DAYS PER YEAR
3 DAYS PER WEEK	6 DAYS PER YEAR
4 DAYS PER WEEK	8 DAYS PER YEAR
5 DAYS PER WEEK	10 DAYS PER YEAR

PLEASE COMPLETE THE FOLLOWING BELOW BASED ON YOUR CHILD'S SCHEDULE...

MY CHILD'S FIRST DAY OF CARE WILL BE: _____

MY CHILD'S VACATION/SICK DAY ANNIVERSARY DATE IS: _____

MY CHILD IS ALLOTTED _____ NUMBER OF VACATION/SICK DAYS

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

SHOE/SNEAKER POLICY

In regard to footwear, children are often building with large blocks, playing outdoors, etc. Because of this, it is preferable that all children have a pair of closed toed shoes for the day. Please remember that your children are here to learn. At this age, this is often accomplished through play. It is very difficult to explain to a child that they cannot play outside or ride cars because they have to protect their new shoes or because they have on flip flops or sandals. They are here to have fun. Please dress them accordingly.

Therefore, our center has the following policy...

- Children are required to wear shoes throughout the day and must arrive to the center with the appropriate shoes already on.
- Shoes should be comfortable and provide adequate protection for the feet during outdoor play.
- Flip-flops, open-toed shoes or sandals are prohibited as they present a safety hazard.
- All walking children must wear shoes. If your child does not have appropriate shoes they will not be allowed to play on the playground equipment-This is for safety reasons.

I, _____ understand the above policy and agree to follow it while my child is enrolled at Sweet Angels Daycare, Inc.

Signed: _____

(Parent or Guardian signature, and date)

Date: _____

Medication Consent Form

I, _____ give
Sweet Angels Daycare permission to apply the following as needed to my child
_____, date of birth _____.

____ Sunscreen

____ Diaper cream (non-prescription only)

____ Triple Antibiotic Ointment

I agree to provide the above items as needed for my child. I understand that if my child needs any other medications, prescription or over the counter that I must have a "Written Medication Consent" (MAT form) filled out by my child's doctor. I understand that Sweet Angels Daycare cannot store or receive any medication without the proper forms fill out.

I understand that I am responsible to provide the center with the above items should I wish for the center to apply them to my child.

(Parent Signature)

(Date)

****This form is for sunscreen, diaper cream and Triple Antibiotic Ointment only.

**All other medications require a Written Consent form
from your child's Pediatrician.**

FOOD/FEEDING POLICY

Our center is affiliated with the NYS Department Health and their Child and Adult Food Program which requires us to serve healthy, nutritionist approved meals and snacks. Our center does not allow children to bring in any food from home or other outside sources. It helps us keep the center a healthy place, and also helps us make sure that no behavior issues arise because one child has food that the other children do not. We also have children with allergies, and we do not want them mistakenly eating something that can make them have a reaction. In addition, please do not send your child in eating food, as they will have residue of possible allergens on their hands, faces, etc.

Therefore...please be aware that any food brought in from home will be either discarded or placed in your child's cubby and they will not be allowed to eat/drink it in the classrooms.

Please also keep in mind that breakfast is served from 8-8:30am and lunch is served from 11:30am-12pm, Afternoon snack is served from 2:30-4pm. If your child will be arriving AFTER 8:30am or 12:00pm please plan on giving your child breakfast/lunch BEFORE they arrive at the center or make prior arrangements with the Director.

In addition, children under 12 months are not allowed to be served whole milk and Infants under 6 months of age are not allowed to be served cereal or soft baby foods.

Thank you in advance for your help and cooperation.

By signing below you are acknowledging that you understand and agree to abide by this policy.

(Parent Signature and date)

INFANT FEEDING STATEMENT

Baby's Name: _____ Date of Birth: _____

Dear Parent/Guardian:

This center/provider participates in the Child and Adult Care Food Program and we will give your baby Parent's Choice Formula and solid food. If you want to bring your own formula or food, you can do that instead. Please let us know your choice by checking below.

FORMULA (CHECK ONE)		FOOD (CHECK ONE)	
<input type="checkbox"/>	The center/provider can give my baby the formula they buy. (PARENT'S CHOICE GENTLE)	<input type="checkbox"/>	The center/provider can give my baby solid foods when I tell them the baby is ready.
<input type="checkbox"/>	I will bring breast milk or formula for my baby.	<input type="checkbox"/>	I will bring solid foods for my baby.

Parent's Signature: _____

Date: _____

PLEASE ONLY FILL OUT IF YOUR CHILD IS BETWEEN 6WKS-12MONTHS.

Formula Consent Form

I, _____, give Sweet Angels Daycare & Preschool permission to prepare and serve formula to my child, _____.

Formula Name: _____ If Breast milk please specify

Feeding Schedule: _____

Instructions to prepare- include temperature, water to formula ratio, etc.

Signature: _____ Date: _____

**PLEASE ONLY FILL OUT IF YOUR CHILD IS
BETWEEN 6WKS-11MONTHS.**

FLIPS GYMNASTICS Permission Slip

Participant's Name: _____ Phone #: _____

Address: _____ Zip: _____

Birth Date: ____/____/____ Age: _____

Parent/guardian, please read and sign the following:

I hereby give permission for my child, _____, to participate in a Gymnastics class held at Sweet Angels Daycare. I will not hold Flips Gymnastics, Sweet Angels or the instructors, employees, or representatives thereof responsible for any injuries or damages that may occur.

I agree to pay \$7.00 per class and will add it to my weekly tuition payment. I understand my child can stop classes at any time should he/she decide they no longer wish to continue taking the class. I sign this release voluntarily.

Parent/Guardian Signature: _____ Date: ____/____/____.

Emergency Contact Name: _____ Phone#: _____.

YOGA Permission Slip

Participant's Name: _____ Phone #: _____

Address: _____ Zip: _____

Birth Date: ____/____/____ Age: _____

Parent/guardian, please read and sign the following:

I hereby give permission for my child, _____, to participate in a Yoga class held at Sweet Angels Daycare. I will not hold, Sweet Angels or the instructors, employees, or representatives thereof responsible for any injuries or damages that may occur.

I agree to pay \$7.00 per class and will add it to my weekly tuition payment. I understand my child can stop classes at any time should he/she decide they no longer wish to continue taking the class. I sign this release voluntarily.

Parent/Guardian Signature: _____ Date: ____/____/____.

Emergency Contact Name: _____ Phone#: _____.

PHYSICAL AND IMMUNIZATION RECORDS AGREEMENT

I, _____ agree to provide Sweet Angels Daycare and Preschool with an updated physical for my child, _____ at least once per year as needed. I also agree to provide Sweet Angels Daycare updated immunization records for my child as needed/required by NYS Daycare Regulations. I understand immunizations are generally administered at every 2, 4, 6, 9, 12, 15 and 18 months of age and again before my child enters Kindergarten. I understand that if I fail to provide current immunization/physical records that my child will not be able to attend daycare until records are provided.

Signature of Parent/Guardian: _____ Date: _____

The following 3 pages must be filled out by ALL children enrolled in our center.

All children enrolled must have a copy of a physical and current immunization records on file BEFORE starting daycare. Children without records will NOT be permitted to attend until all forms are turned in. ALL children must have a completed Income Eligibility Form on file at the center and must be renewed annually.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician's Assistant or Nurse Practitioner

Name of Child:	Date of Birth:	Date of Examination:
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Immunizations required for entry into day care

Yes No

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).

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1 st Date	2 nd Date	3 rd Date	4 th Date	5 th Date
Polio (IPV or OPV)	1 st Date	2 nd Date	3 rd Date	4 th Date	
Haemophilus influenzae type B (Hib)	1 st Date	2 nd Date	3 rd Date	4 th Date OR 1 st Date (if given on or after 15 months of age)	
Pneumococcal Conjugate (PCV) for those born on or after 1/1/08)	1 st Date	2 nd Date	3 rd Date	4 th Date	
Hepatitis B	1 st Date	2 nd Date	3 rd Date		
Measles, Mumps and Rubella (MMR)	1 st Date	2 nd Date			
Varicella (also known as Chicken Pox)	1 st Date	2 nd 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)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is medication regularly taken? (Specify drug and condition)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is a special diet required? (Specify diet and condition)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any hearing, visual or dental conditions requiring special attention?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any medical or developmental conditions requiring special attention?	<input type="checkbox"/> Yes <input type="checkbox"/> 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

Religious Exemptions

Public Health law Section 2164 allows a child to be religiously exempted from immunization. A written and signed statement from a parent, parents or guardian of the child stating that they object of the immunization of their child due to their sincere and genuine religious beliefs should be submitted to the day care owner, operator or administrator who shall determine whether the statement of religious belief is acceptable.

Sweet Angels Daycare and Preschool
6441 Dysinger Road
Lockport, NY 14094

Automatic Debit Authorization Form

(Please note there is a 4% convenience fee added to process your payment)

Child/Children's Name: _____

Name on the Card: _____

Type of Card: Visa ___ MC ___ AmEx ___ Discover ___ Other ___

Account number _____

Expiration Date _____

Security Code _____

Billing Address _____

City, State, Zip _____

Phone Number _____

Amount to be charged: \$ _____ - PLEASE ADD 4% TO TOTAL

_____ I would like receipts emailed to: _____

_____ I would like receipts via text message to: _____

_____ I would like a paper copy of my receipt

By signing this form, you authorize Sweet Angels Daycare to charge your card tuition as agreed upon in your contract every Friday. Payments will be debited every Friday before 6pm.

Signature: _____ Date: _____

