

Church Street Community Nursery School

4 Church Street
Red hook, NY 12571
(845)-758-6282

Churchstreet@frontiernet.net

Background Information

Child's Name: _____ Nickname: _____

Gender: Male or Female

Home Address: _____

Home Phone: _____ Year entering Kindergarten: _____

Date of Birth: _____ Home School District: _____

Guardian's Name: _____ Occupation: _____

Home Address: (if different) _____

Cell Phone: _____

Email: _____

Guardian's Name: _____ Occupation: _____

Home Address: (if different) _____

Cell Phone: _____

Email: _____

Names & Ages of Siblings

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

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

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

Do you have concerns about your child's development? _____

What experiences has your child had away from home? _____

With whom does your child spend time with during the day? _____

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

Habits

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

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

What terminology does your child use (bathroom)? _____

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

Discipline

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

Playtime Interests

Favorite Plaything or activity _____

Does your child play well with others? _____

Does your child play well on their own? _____

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

Personality

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

Does your child seek the attention of adults? _____

What are your child's fears? _____

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

Health History

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

*Asthma

*Frequent Colds

*Sore Throats

*Diabetes

*Bronchitis

*Seizures

*Ear Infections

*Stomach Upsets

*Kidney/Bladder Troubles

*Heart Issues

*Fainting/Dizzy Spells

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

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

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

Prepared By _____ Date _____

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: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Caretaker <input type="checkbox"/> Relative _____ <input type="checkbox"/> Other _____			
PHONE NUMBER(S) OF PERSON ENROLLING CHILD: () - <input type="checkbox"/> ok to text				ADDRESS OF PERSON ENROLLING CHILD (IF DIFFERENT THAN CHILD):			
EMAIL ADDRESS:							
EMERGENCY INFO	EMERGENCY CONTACT NAMES / ADDRESSES		Authorized to Pick Up Child	PRIMARY PHONE NUMBER		OTHER PHONE NUMBER / EMAIL	
	PRIMARY CONTACT:		<input type="checkbox"/> Yes <input type="checkbox"/> No	() - <input type="checkbox"/> ok to text		() - <input type="checkbox"/> ok to text	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	() - <input type="checkbox"/> ok to text		() - <input type="checkbox"/> ok to text	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	() - <input type="checkbox"/> ok to text		() - <input type="checkbox"/> 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: <input type="checkbox"/> None			
<input type="checkbox"/> Early Intervention/Special Education	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Speech/Language	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Allergies (Please list) _____ <input type="checkbox"/> 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.....			<input type="checkbox"/> Yes <input type="checkbox"/> 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.....			<input type="checkbox"/> Yes <input type="checkbox"/> No
• I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips.....			<input type="checkbox"/> Yes <input type="checkbox"/> No
• I provided information on my child's special needs to the program to assist in caring for my child.....			<input type="checkbox"/> Yes <input type="checkbox"/> No
• I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation.....			<input type="checkbox"/> Yes <input type="checkbox"/> No
• I agree to review and update this information whenever a change occurs and at least once every year.....			<input type="checkbox"/> Yes <input type="checkbox"/> No
SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:			DATE: / /

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)	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

Church Street Community Nursery School

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

Parental Consent Form

I give permission for my child, _____ to participate in ALL field trips that Church Street Community Nursery School plans.

This may include but not limited to:

- Walking field trips to the Post Office, Village Pizza, Police Station, Library, Trick or Treating
- Pre-K bus ride
- Apple Picking, Pumpkin Picking, Forsyth Park, Holy Cow, etc (**you will be asked to provide transportation**)

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

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

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

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

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

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

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

Name: _____ **Relationship to child** _____

Phone Number: _____

Name: _____ **Relationship to child** _____

Phone Number: _____



Communication Consent Form

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

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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

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

Print Name: _____

Date: _____

Parent Signature: _____