Ossining Children's Center

APPLICATION FOR INFANTS & TODDLERS

SPECIAL DISABILITIES (PHYSICAL, LEARNING, SPEECH, ETC.), ALLERGIES OR OTHER PROBLEMS:
_____
_____

THIS APPLICATION MUST BE ACCOMPANIED BY YOUR CHILD'S BIRTH CERTIFICATE
APPLICATION FOR ENROLLMENT
DEPOSITS ARE NONREFUNDABLE: Deposit amount paid_____ Date received_____

Today's Date:_____ Date $25.00 Non- Refundable Application Fee Paid:_____
Requested Starting Date:_____ CHECK/CASH RECEIPT #_____ Received by:_____

Child's Name:_____ Circle: Male / Female

Child's Nickname:_____ Date of Birth:_____ Age:_____
Child's Address:_____

Guardian #1 Name: _____ Cell: _____
Relation to Child: _____ Home Phone: _____
Address: _____
Email: _____
Occupation: _____ Present Position: _____
Name and Address of Employer:_____
_____ Work # :_____

Guardian #2 Name: _____ Cell: _____
Relation to Child: _____ Home Phone: _____
Address: _____
Email: _____
Occupation: _____ Present Position: _____
Name and Address of Employer:_____
_____ Work # :_____

Limitations on Visitation Rights: _____
DSS case worker:_____ DSS case #_____ Phone #_____

How many people live in your household? _____

Please list all household members not described above:

Name	Relationship	Age	Health	Employed	Home	School	Grade

How did you learn about the Ossining Children's Center? Please check all that apply:

_____ from a friend or family member
_____ Google Search
_____ Ad on a Grocery Cart
_____ Other (please specify) _____
_____ Sign on the building at 32 State Street
_____ Facebook group
_____ Welcome Wagon

What language(s) are spoken in your home? _____

Has your child ever been in the care (even for brief periods) of anyone other than yourself? _____. If so, when, with whom, and for what periods of time?

_____

Please give us information about your child's habits and need:

Allergies _____

Special Health Conditions _____

Special Interests and Abilities _____

Ways your child communicates his/her needs _____

Comforting Needs _____

Naptime Habits _____

Toileting Habits _____

Eating Habits _____

Diet: Type of formula _____
Ounces per serving: _____Times per day: _____

Type of Food Amount per Serving Times per Day

Cereal _____
Fruit _____
Meat/ Protein _____
Vegetables
_____
Fluids (juice, water, etc.) _____
Other foods _____

I give the Ossining Children's Center permission to use wet wipes and over-the-counter diaper rash ointments on my child as I direct.

_____ _____
Parent / Guardian signature Date

CHILD DEVELOPMENT (INFANTS AND TODDLERS):

1. Was your child's birth normal? _____ Any problems?_____
   _____
   _____
2. At what age did your child:
   Walk?_____ Talk?_____ Toilet Trained?_____
   Does your child have any special routines or words about toileting? _____
   _____
3. Describe your child's sleeping habits? _____
   _____ Nap? _____
4. Has your child been identified by a professional as having any type of learning disabilities or other developmental delay? _____
   _____

MEDICAL:

DOES YOUR CHILD HAVE ANY SPECIAL DISABILITIES, ALLERGIES, OR OTHER MEDICAL PROBLEMS WE SHOULD KNOW ABOUT? _____
_____
_____

Pediatrician _____

Address _____ Telephone_____

Last Physical Examination on (Date) _____

Summary _____
_____

_

Growth Rate: Normal _____ Slow _____ Rapid _____

Has your child had:

Spasms _____	Frequent Colds _____
Convulsions _____	Nosebleeds _____
Injuries _____	Speech Difficulties _____
Surgery _____	Dental Problems _____

ANY unusual experiences regarding health?_____

ENROLLMENT STATEMENT

_____, age _____ is enrolled at the Ossining Children's Center, 32 State Street, Ossining, NY 10562, commencing on _____

Signatures: _____

Parent/ Guardian Date

Children withdrawn from enrollment on _____ .

Date

Comments:

_____

_____

_____

Signatures: _____

Parent/ Guardian Date

Child's Name_____ Home Telephone _____

Address_____ Date of Birth _____

1. I hereby give my permission to the OSSINING CHILDREN'S CENTER to seek EMERGENCY MEDICAL TREATMENT for my child in case I am unavailable when such treatment is required. I will bear all medical expenses for this treatment.

   _____

   Signature Date

   Pediatrician: _____

   Name Address Telephone

2. In case of emergency, the following three persons (more, if possible) will be called and are authorized to pick up my child:

   Name Relationship To Child Address (7AM-6PM) Telephone (CELL/ WORK)

1. _____

2. _____

3. _____

_____

Signature(s) Date

3. I assume responsibility for my child from the time he/she leaves home until arrival at the Center and from the time he/she leaves the Center at the end of the day.

   _____

   Signature(s) Date

4. _____ will pick up my child from the Center at approximately_____ each day. I hereby agree to notify the Center office each time any other person will pick up my child from the Center.

   _____

   Signature(s) Date

5. I hereby give my permission for my child to go on educational trips under the jurisdiction of the Ossining Children's Center with ample and mature supervision.

   _____

   Signature(s) Date

6. I hereby give my permission for my child to appear in the photographs taken by the Center and to allow any pictures of my child to be released for publication, electronic or print, for the purpose of fundraising or public relations.

   _____

   Signature(s) Date

7. I hereby give my permission for my child to be seen by the OCC psycho- educational consultant for initial and follow-up assessment screenings.

   _____

   Signature(s) Date

INCOME STATEMENT

Child's Name_____

Number of Family/ Household Members_____

Number of Children in Day Care:

Full-Time _____ Part-Time _____ Total _____

Four Payroll Stubs Submitted _____

GROSS INCOME SOURCES (S):

Salary (Father/_____):	_____	_____	_____	_____	_____
Salary (Mother/_____):	_____	_____	_____	_____	_____
Support Payments:	_____	_____	_____	_____	_____
Social Security:	_____	_____	_____	_____	_____
DSS/ ADC:	_____	_____	_____	_____	_____
Alimony:	_____	_____	_____	_____	_____
Other (Specify:_____):	_____	_____	_____	_____	_____

TOTAL GROSS INCOME: _____

FALSIFICATION OF THE ABOVE INFORMATION SHALL RESULT IN THE TERMINATION OF YOUR CHILD'S PARTICIPATION IN OUR PROGRAM. FOUR PAYROLL STUBS FOR EACH WAGE EARNER IN THE HOUSEHOLD **MUST** ACCOMPANY THIS FORM.

THE OFFICE IS TO BE NOTIFIED IMMEDIATELY IF THERE IS ANY CHANGE IN GROSS INCOME.
INCOME SUBJECT TO VERIFICATION TWICE YEARLY.

Signature:

_____ _____ _____

Parent/ Guardian Soc. Sec. # Date

FEE SCHEDULE

CHILD(REN'S) NAME(S) _____

PROGRAM	FIRST CHILD	SIBLING	SIBLING
A) INFANT/ TODDLER	_____	_____	_____
B) NURSERY	_____	_____	_____
C) PRE- SCHOOL	_____	_____	_____
D) UNIVERSAL PRE-K	_____	_____	_____
E) KINDERGARTEN	_____	_____	_____
F) AFTER- SCHOOL	_____	_____	_____
G) BUS & BREAKFAST	_____	_____	_____
SUBTOTALS:	_____	_____	_____

TOTAL WEEKLY FAMILY FEE: _____

ADDITIONAL WEEKLY RATE FOR FULL DAY FOR AFTER-SCHOOL STUDENTS: _____

****

****

I hereby agree to pay $ _____ weekly to the OSSINING CHILDREN'S CENTER for the care of my child:

_____ beginning on _____.

_____ _____

Parent/ Guardian Date

POLICY STATEMENT

The Ossining Children's Center is open to all children regardless of race, creed, or ethnic origin.

For a child to be admitted to the Center, the parent(s) must complete and sign the forms presented by the Center including:

A. Application for Enrollment
B. Permission Forms
C. Income Statement and Fee Schedule
D. CACFP Form
E. Title XX Form (when applicable)
F. Policy Statement
G. Health Form (completed by a physician) required annually

INCOME VERIFICATION

- Income verification may be required twice a year for all parents whose children attend the Center.

TUITION

- Tuition fees are due on Friday for each forthcoming week. Fees may be based on a sliding scale and are adjusted whenever there is a change in income. Fee increases for parents who fail to provide income verification are retroactive to the last verification date. Fee decreases are not retroactive.

- Parents are responsible for the entire tuition even if the child is absent. However, if a child is absent for the entire week, fee will be half of the regular weekly fee.

- Part-time school-age students' tuition will be charged at the full-day tuition rate for full weeks (i.e. school vacation weeks).

- Parents who are eligible for government funding but who refuse to accept funding *or* who fail to submit the required documents in an accurate and timely manner will be required to pay a fee equal to the amount of the funding they refuse.

- If a parent falls ***two*** weeks behind in payment of tuition fees, the child will not be allowed to attend the Ossining Children's Center until such payments are brought up-to-date.

PAST-DUE ACCOUNTS

- Past due accounts of children who have left the Center with an outstanding balance will be transferred to an attorney and the cost of collection will be added to the overdue account.

HOURS

- The hours of the Ossining Children's Center are from 7:00 a.m. to 5:55 p.m.

- Arrival should be between 7:00 a.m. and 10:00 a.m. unless otherwise noted.

- CHILDREN MUST BE SIGNED IN AND OUT ON THE CLIPBOARD UPON ARRIVAL AND AT PICK UP.

I have read the above statements and will abide by the policies of the OSSINING CHILDREN'S CENTER.

_____ _____

Parent/Guardian Date

- The Center closes promptly at 5:55 p.m. each day. If a child is picked up by 6:00p.m a late fee of $10.00 for every 20 minutes or part thereof will be charged. The parent will be asked to record in the late fees book the time of arrival, the child's name and their signature. The fee will be due with regular tuition fees.

- Parents who arrive late consistently (more than four-six times in a month) will be requested to find childcare which more suits their individual needs.

- If a child is not picked up by 7:00 p.m. and a call has not been received from the parents or the Center has been unable to contact any of the family's designated emergency numbers, the child will be taken to the Ossining Police Station.

FOOD

- All Center menus, consisting of breakfast, lunch, and snack each full day, are approved by a nutritionist.

- With the exception of infant formula, the Center will provide each full-time child with at least two-thirds of his daily food requirement. Children attending a part-time program without lunch will receive at least one nutritious snack. Other part-time children will receive snack and lunch.

- Menus will be dated and posted on the bulletin board in the entrance hall.

HEALTH

- The Center has arranged for group accident insurance coverage for all children for accidents occurring while children are under the Center's care. All parents are required to pay the insurance fee with the first week's tuition and each September thereafter.

- Children are required to have physical examinations once a year as preschoolers and once every two years as school-agers. Children will not be admitted to the Center without an up-to-date medical examination and a health form on file.

- The children are given a routine check every day upon arrival. Any child who shows symptoms of infection will have to be returned home.

EXCLUSION GUIDELINES

The following symptoms could represent communicable diseases and are reasons for excluding children:
Diarrhea- two or more loose stools (with increased stool water and/or decreased form) or of stools contain blood or mucus.
Vomiting- two or more times in previous twenty- four hours unless physician determines vomiting is not due to communicable condition and child is not in danger of dehydration.
Fever- 101 or higher
Any child with these symptoms should remain at home for 24 hours after the symptoms are gone.

MEDICATION

- The Center may not administer any medication or special diet without written instructions from a physician.

PERSONAL BELONGINGS

- The Ossining Children's Center cannot be held responsible for lost items. Please label all of your child's belongings with his or her name: clothing, blankets, naptime stuffed animals, etc.

I have read the above statements and will abide by the policies of the OSSINING CHILDREN'S CENTER.

_____ _____

Parent/Guardian Date

CONFERENCES

- Conferences are scheduled with teachers in February and June. Parents may request a teacher conference at any time.

TERMINATION

- The Center reserves the right to terminate a child from the Center if it is determined that our program does not meet the needs for a child.

I have read the above statements and will abide by the policies of the OSSINING CHILDREN'S CENTER.

_____ _____

Parent/Guardian Date

THIS FORM MUST BE COMPLETED REGARDLESS OF INCOME LEVEL *
* TIENE QUE SER COMPLETADO *

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 Ossining Children's Center

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

1. _____ 2. _____ 3. _____

DIRECTIONS

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 SPONSOR USE ONLY

CACFP Agreement # 30860

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 get Federal funds based on the information I give.

Signature _____

Print Name _____

LAST FOUR (4) DIGITS OF SOCIAL SECURITY NUMBER [ ][ ][ ][ ]

DATE _____

USDA is an equal opportunity provider and employer.

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

OSSINING CHILDREN'S CENTER

Where Children Learn to Love Learning

AUTHORIZATION FOR CREDIT CARD USE

PLEASE COMPLETE THIS AUTHORIZATION AND RETURN
All information will remain confidential

Name on card: _____

Billing address: _____

_____

Phone number: _____

Child(ren) name: _____

Credit card type: _____ Visa _____MasterCard _____AmEx

Credit card number: _____

Expiration date: _____ Security code: _____

Amount to charge: $25.00 (per registration)

I authorize the Ossining Children's Center to charge the credit card provided. I agree to pay for this registration fee in accordance with the issuing bank cardholder agreement.

Cardholder – please sign and date

Signature: _____

Printed name:_____

Date: _____