



After School Program Registration Checklist

Student Name: _____ DOB: _____ Grade: _____

Parent/Guardian: _____ Phone: _____

Email: _____

Please **initial** that the following forms have been completed and handed in to staff:

- | | |
|-----------------------------------|--|
| _____ OCFS Blue Card registration | _____ Alyssa's Law Acknowledgement |
| _____ Shelter in Place Policy | _____ Consent for Medical Treatment Form |
| _____ Media Consent Form | _____ Child in Care Medical Statement |

Summer ONLY: _____ Non – Medication Consent Form (Sunscreen Form)

Please **initial** acknowledgement of each items listed below:

_____ I am aware that all registration paperwork is valid for a year and that I will be asked to initial and date every 3 – 6 months to verify that there haven't been any changes. If there are any changes, I agree to let the staff know immediately.

_____ I am aware that there is a strict NO nut and NO coconut food policy for all programs.

_____ I have received a copy of the Parent Handbook and am aware that this includes the behavior management procedures. I agree to abide by all policies outlined in the Parent Handbook

_____ I am aware that no firearms, shotguns or rifles are permitted on the premises.

_____ I am aware that my child will be highly encouraged to participate in homework assistance or educational enrichment activities between 3:45 – 4:15 daily. (Reading, Math, computer school programs etc)

_____ My child has permission to participate in the RSCC After School Program. I will notify staff by calling 315-858-3200 if my child will be absent. I acknowledge that staff will call all emergency contacts until they are able to confirm child's location if they are not notified that he or she will be absent.

_____ At the end of the program's day, I give permission for my child to be released to one of the emergency contacts listed on his/her blue card. I understand that my child cannot be released until an authorized adult signs them out. Pick up person should always bring a form of ID.

I understand that the above forms need to be completed and handed in before my child can attend the Summer or After School Program. By signing this form I agree to comply with the above initialed statements.

Parent Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

To be completed at 6 month review: The above forms were reviewed on _____ and _____ verified all information is current.
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June 4, 2018

Dear Parent/Guardian,

Our NY State Child Care license requires we have a plan and policy in place should an emergency arise where it is safer to remain in the building rather than to evacuate. Some situations that might require us to enact this "Shelter in Place" plan include: severe weather conditions, extreme temperatures, a public disturbance that escalated to violent acts, a chemical or biological spill, or a rabid animal sighting. Local Authorities will provide us with information and instructions during an actual event. In a real emergency, you may be unable to pick up your child. Our plan has taken into account the needs of a possible overnight stay.

If this is necessary, program staff will notify you via telephone, as soon as possible. We are prepared at the center with extra food, water, and emergency supplies should this become necessary. Two annual drills will be conducted as required by the Office of Child and Family Services. We will notify you in advance of our drills.

Please sign and return the bottom portion of this notice for our records. Feel free to contact me if you have any questions.

Thank You,

Laura Neff
Director

Richfield Springs Community Center
PO Box 108 - Richfield Springs, NY 13439 - 315.858.3200
www.richfieldspringscommunitycenter.org

Please return the bottom portion with signature.

I have received a copy of the Community Center PLAY program Shelter in place policy.

Parent/Guardian Signature: _____

Parent/Guardian Name: _____ Date: _____



Media Publication Consent Form

From time to time, the R.S.C.C. uses photographs and/or video of our programs and their participants, published in various forms of media, to promote our Community Center and advertise our events and activities. Please sign below to give consent for your child to be photographed at the Community Center sponsored programs, and allow us to use these photographs for such purposes as, but not limited to, newspaper articles, our website or brochures, our newsletter, and display photograph boards for community events and grant presentations.

I give my consent for my child to appear in photographs which may be published for Community Center Promotional purposes.

Student's Name: _____

Print Parent/Guardian's Name: _____

Parent/Guardian Signature: _____

Date: _____

Richfield Springs Community Center
PO Box 108 - Richfield Springs, NY 13439 - 315.858.3200
www.richfieldspringscommunitycenter.org



Alyssa's Law Acknowledgement

I, _____ (print parent/guardian name) acknowledge that I am aware that my child care provider, Richfield Springs Community Center, has a body of water on or adjacent to the Family Day Care property. On the east end of the property, there is a ditch/creek that periodically has water in it. There is also an active creek that runs along Ann Street and between the property and the school.

I acknowledge that my child, _____ may have the potential for access to the bodies of water described above. My child care provider, Richfield Springs Community Center, has taken the following steps to prevent children from having access to the body of water described above:

While playing outside the children will be supervised by staff members. Staff will be positioned on both sides of the designated play area as to keep the children in the designated play area and away from the creek located east of the facility. Cones will be used to designate the play area.

Provider's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____

CONSENT FOR MEDICAL/SURGICAL CARE
EMERGENCY TREATMENT
AND CHILD'S MEDICAL INFORMATION

Representing my son/daughter for diagnosis treatment

Name: _____ for _____

Mother Father Legal Guardian Son Daughter

_____ years of age; hereby voluntarily consent to the rendering of such care including diagnostic procedures, surgical medical treatment and blood transfusion, by authorized members of the hospital staff of their designees, as many in their professional judgement be necessary.

We/I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on child's condition.

We/I have read this form and I certify the I understand its contents.

We/I hereby give our/my consent to _____

Who will be caring for our/my child _____

For the period _____ to _____ to arrange for routine emergency medical, surgical, dental care and treatment necessary to preserve the health of our/my child.

We/I acknowledge that we/I am responsible for all charges in connection with care and treatment rendered during this period.

Name: _____ Family Physician: _____

Address: _____ Pediatrician: _____

_____ Surgeon: _____

Telephone No: _____ Orthopedist: _____

Name or Health Insurance Carrier: _____ Child's allergies, if any: _____

_____ Date of last tetanus booster: _____

Group No: _____ Medicines child is taking: _____

Agreement: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

IN CASE OF EMERGENCY I CAN BE REACHED AT: _____

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).

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

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.

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 repellent.
- 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: <input type="checkbox"/> 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:		
<input type="checkbox"/> Contact parent _____		
Other (describe): _____		
10A. Special instructions: <input type="checkbox"/> 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. Facility ID number:	17. Program telephone number:
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:	
21. Staff's signature:		
X		