

DAYCARE REGISTRATION CONTRACT

I, _____, residing _____
(Parent's Last & First Name) (Address)

agree to register my son/daughter _____
(Child's Last & First Name)

to A to Z Daycare Center undertake to pay \$_____ per month as a tuition fee. The tuition is due the first of each month (late payment charge of \$50 will be added for payments made after 5th of each month.)

I understand that this amount covers expenses for attendance of my son/daughter of the daycare center at A to Z Daycare Center, use of all programs, educational instructions, supervision, educational materials, toys, participation in all daycare center activities, daily meals (3 times a day). This amount does not include any trips or activities outside of the daycare center, physicians' fees, hospital fees, or medicine other than provided by standard daycare center emergency procedures.

I understand that there are no deductions for any absence in case of illness, vacations or other reasons. Full payment is due regardless of government or religious holidays included in the Daycare's Annual Calendar.

For the safety, welfare and proper maintenance of all children of A to Z daycare Center, retains the right to terminate this Contract without notice for the following reasons:

- *The child (ren)'s behavior is destructive, uncontrollable, violent, or threatening to the other children or providers at the care facility. This determination is made in the sole discretion of the Provider.
- * A Parent's behavior is threatening or abusive to the other children or providers at the care facility.
- * Childcare fees are 10 days or more delinquent.
- * The child (ren) is absent for 14 days or more without reasonable explanation or payment from the Parent(s).
- * Misrepresentation regarding the medical or mental history of a student. In such an event there will be no refund or adjustment of any part of the daycare center fee. The daycare shall have further right to charge and receive collection of attorney's fees on any unpaid balance plus interest, expenses and court costs, if any, in the event that the daycare initiates proceedings for the collection on any unpaid balance due.

In case of a medical emergency, A to Z Daycare Center shall obtain the necessary emergency medical care for the child (ren), including but not limited to transportation to an emergency room. The Parent(s) agrees to pay all costs and expenses incurred in connection with any medical care provided to the child, including the cost of transportation. I understand that A to Z Daycare Center will make every effort to contact my emergency contact or myself before or immediately after such emergency treatment is rendered.

Permission hereby granted A to Z Daycare Center to use any photographs, film or video, of the above student in any public release, publicity, and advertisement of brochures, television program, promotional video or daycare's web sites.

Parent/guardian further agrees to waive the right to press legal charges against A to Z Daycare Center, its officers, directors, and employees, in those instances where any of the above have not clearly demonstrated negligence leading to injury of the above named child.

I hereby confirm that the above named child is in good physical condition and has been examined by a physician within the past 6(six) months and is in relatively good health and able to participate in a full to A to Z Daycare Center educational and sport programs.

I understand that I have to pick-up my child at or before 6:30 PM and drop off my child not earlier then 7:30 AM to the daycare premises. I understand if I am late to pick-up my child or earlier then our open hours before the above stated time there will be additional charge of \$1.00 per minute the child spends in the daycare center. This payment should be made at the time of late pick up/early drop off to the staff that is present with your child.

If child is out of daycare center sick for more than 3 days parents are obligated to submit a doctor's notice upon the child's return.

Parents must notify daycare center's office in writing for all changes of address, telephone numbers, and emergency contacts not later than 7 business days after changes occur.

I have read the Agreement of the Enrollment terms, which are previously stated in Agreement and agree that this enrollment acceptable to me and is subject to everything containing therein. In the event one parent executes this agreement, I acknowledge that I am also acting as the agent of the other parent with the authority to enroll my child into A to Z Daycare Center and agree to execute this agreement on his or her behalf. I recognize that A to Z Daycare Center relies upon the representation herein made in accepting my child to A to Z Daycare Center.

Parent's Signature _____ Date _____

EMERGENCY MEDICAL RELEASE AGREEMENT

As the parent or legal guardian of:

(Child's Last and First Name)

I, give my permission for my child to receive whatever emergency medical care that may be deemed needed to A to Z Daycare Center personnel for the treatment of any injury that may be incurred while in the activities on premises or elsewhere.

I understand that A to Z Daycare Center will make effort to contact myself or my emergency contact before or immediately after such emergency treatment is rendered.

Signature

Date

MEDICAL INSURANCE INFORMATION

NAME OF PRIMARY INSURER -----

NAME OF CHILD'S MEDICAL INSURANCE COMPANY -----

CONTRACT # -----

GROUP# -----

ID# -----

(Please include a copy of your medical insurance card)

MEDICAL RELEASE

As a parent or legal guardian of:

(Child's Last and First Name)

I hereby confirm that the above named person is in good physical condition and has been examined by a physician with the last 6 (six) months and is in relatively good health and able to participate in a full A to Z Daycare Center education, recreation and sport programs.

Signature

Date

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I do hereby give authority to A to z daycare Center staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Signature _____ Date ____/____/____

LIMITED WAIVER OF LIABILITY

A to Z Daycare Center provides serious education, recreation and sport programs. Our staff is trained to provide the maximum of protection for your child while in our care. Even with all of these safeguards injuries can occur. As a parent or legal guardian of the above named student, I fully understand the risks involved in my child's participation in all the daycare's activities. To the best of my knowledge my child has no medical conditions, which would conflict with his/her participation in the A to Z Daycare Center's education, sport and recreation programs. I further agree to waive the right to press legal charges against A to Z Daycare Center, its officers and staff, in those instances where any of the above have not clearly demonstrated negligence leading to injury of the above named child.

Signature

Date

DRESS CODE

Below you will find clarification on what articles of clothing can and cannot be worn to daycare. This list is being provided to you so that there will be no confusion as to what is appropriate and what is not appropriate.

- 1. Footwear must be worn at all times. Footwear that is considered unsafe such as, loose sandals, flip flops, shower shoes, wheelie shoes and the like, are not permitted.
- 2. Hats or other head coverings, except in the case of religious observance, may not be worn in the building.
- 3. No clothing may be worn that promoted illegal substances, alcohol or tobacco products. In addition, clothing with messages or graphics deemed offensive, profane, violent, derogatory or otherwise inappropriate is not permitted.

Signature

Date

CHILD & ADOLESCENT HEALTH EXAMINATION FORM
 NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please
 Print Clearly
 Press Hard

STUDENT ID NUMBER OSIS

TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name _____ First Name _____ Middle Name _____ Sex Female Male Date of Birth (Month/Day/Year) ____/____/____

Child's Address _____ Hispanic/Latino? Yes No Race (Check ALL that apply) American Indian Asian Black White
 Native Hawaiian/Pacific Islander Other _____

City/Borough _____ State _____ Zip Code _____ School/Center/Camp Name _____ District _____ Phone Numbers
 Number _____ Home _____
 Cell _____
 Work _____

Health insurance Yes Parent/Guardian Last Name _____ First Name _____
 (including Medicaid)? No Foster Parent

TO BE COMPLETED BY HEALTH CARE PROVIDER If "yes" to any item, please explain (attach addendum, if needed)

Birth history (age 0-6 yrs)
 Uncomplicated Premature: _____ weeks gestation
 Complicated by _____

Allergies None Epi pen prescribed
 Drugs (list) _____
 Foods (list) _____
 Other (list) _____

Does the child/adolescent have a past or present medical history of the following?
 If persistent, check all current medication(s): Inhaled corticosteroid Other controller Quick relief med Oral steroid None

Asthma (check severity and attach MAF/Asthma Action Plan): Intermittent Mild Persistent Moderate Persistent Severe Persistent

Attention Deficit Hyperactivity Disorder Orthopedic injury/disability
 Chronic or recurrent otitis media Seizure disorder
 Congenital or acquired heart disorder Speech, hearing, or visual impairment
 Developmental/learning problem Tuberculosis (latent infection or disease)
 Diabetes (attach MAF) Other (specify) _____

Medications (attach MAF if in-school medication needed)
 None Yes (list below) _____

Dietary Restrictions
 None Yes (list below) _____

Explain all checked items above or on addendum

PHYSICAL EXAMINATION

Height _____ cm (____ %ile) **General Appearance:**
 Weight _____ kg (____ %ile) NI Abnl HEENT NI Abnl Lymph nodes NI Abnl Abdomen NI Abnl Skin NI Abnl Psychosocial Development
 BMI _____ kg/m² (____ %ile) Dental Lungs Genitourinary Neurological Language
 Head Circumference (age <2 yrs) _____ cm (____ %ile) Neck Cardiovascular Extremities Back/spine Behavioral
 Blood Pressure (age >3 yrs) _____ / _____ Describe abnormalities: _____

DEVELOPMENTAL (age 0-6 yrs) Within normal limits
 If delay suspected, specify below
 Cognitive (e.g., play skills) _____
 Communication/Language _____
 Social/Emotional _____
 Adaptive/Self-Help _____
 Motor _____

SCREENING TESTS	Date Done	Results	Date Done	Results
Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk)	____/____/____	____ µg/dL	Tuberculosis <i>Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school</i>	____/____/____
Lead Risk Assessment (annually, age 6 mo-6 yrs)	____/____/____	<input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk	PPD/Mantoux placed	____/____/____
Hearing <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE	____/____/____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	PPD/Mantoux read	____/____/____
Hemoglobin or Hematocrit (age 9-12 mo)	____/____/____	____ g/dL ____ %	Interferon Test	____/____/____
			Chest x-ray (if PPD or Interferon positive)	____/____/____
			Vision (required for new school entrants and children age 4-7 yrs)	____/____/____

Induration _____ mm
 Neg Pos
 Neg Pos
 NI Not Indicated
 Abnl
 Acuity Right ____/____
 Left ____/____
 Strabismus No Yes

IMMUNIZATIONS - DATES CIR Number of Child

Hep B _____
 Rotavirus _____
 DTP/DTaP/DT _____
 Hib _____
 PCV _____
 Polio _____

Influenza _____
 MMR _____
 Varicella _____
 Td _____
 Tdap _____ Hep A _____
 Meningococcal _____
 HPV _____
 Other, specify: _____

RECOMMENDATIONS Full physical activity Full diet
 Restrictions (specify) _____

Follow-up Needed No Yes, for _____ Appt. date: ____/____/____

Referral(s): None Early Intervention Special Education Dental Vision
 Other _____

ASSESSMENT Well Child (V20.2) Diagnoses/Problems (list) _____ ICD-9 Code _____

Health Care Provider Signature _____ Date ____/____/____

Health Care Provider Name and Degree (print) _____ Provider License No. and State _____

Facility Name _____ National Provider Identifier (NPI) _____

Address _____ City _____ State _____ Zip _____

Telephone (____) _____ - _____ Fax (____) _____ - _____

DOHMH PROVIDER ONLY I.D.

TYPE OF EXAM: NAE Current NAE Prior Year(s)
 Comments _____

Date Reviewed: ____/____/____ I.D. NUMBER

REVIEWER: _____

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME: _____

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. Receives Food Stamps
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR)
4. Currently has a foster child enrolled in day care

SECTION A	
Food Stamp Case Number	
TANF Number	
FDPIR Number	
Foster Child's Name	
Foster Child's Personal Monthly Income	\$ _____
<p>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.</p> <p>I certify that the above information is true and correct and that all income is reported. I understand this information is being given for the receipt of Federal funds, that officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.</p>	
Signature: _____	
Date: _____	
FOR SPONSOR USE ONLY	
Sponsor Agreement Number _____	
Total Household Members _____	
Total Income \$ _____	
Free _____	Reduced _____ Paid _____
Signature of Determining Official _____	
Date Determined ____ / ____ / ____	

Complete SECTION B if SECTION A does not apply:

Sign, date and indicate the Social Security number of the adult signing the certification and return the completed form to the day care center.

SECTION B	
<p>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, welfare payments, child support and any other sources of income.</p>	
Name of Household Members	Monthly Gross Income
1. _____	\$ _____
2. _____	\$ _____
3. _____	\$ _____
4. _____	\$ _____
5. _____	\$ _____
6. _____	\$ _____
<p>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.</p> <p>I certify that the above information is true and correct and that all income is reported. I understand this information is being given for the receipt of Federal funds, that officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.</p>	
Signature: _____	
Print Name: _____	
SS# _____	Date: _____