NYS BLUE FORM **PARENT BOX #_____**

Enrollment and Registration for child attending Rainbow Junction Child Care Center

226 Keuka Street Penn Yan, NY 14527 315-536-2703 NYS OCFS BECS LICENSE #00040612 DCC

CHILD'S FULL NAME:_____BIRTHDATE_____/_____/_____ M____ F____
CHILD'S HOME ADDRESS:_____ ENROLLMENT DATE_____/_____/_____
_____DISCHARGE DATE_____/_____/_____

PERSON/S RESPONSIBLE FOR CHILD: Mom_____Dad_____
PARENT____GUARDIAN____CARETAKER____RELATIVE____OTHER_____
ADDRESS OF PERSON LISTED ABOVE (IF DIFFERENT FROM CHILD'S)_____

MOM'S PHONE: HOME_____ CELL_____EMPLOYER_____WORK PHONE_____
DAD'S PHONE: HOME_____ CELL_____EMPLOYER_____WORK PHONE_____

CUSTODIAL/GUARDIAN INFORMATION (REQUIRED TO ATTACH COPIES OF DOCUMENTS)

EMERGENCY CONTACT INFORMATION

PERSON OR PERSONS WHO MAY BE CONTACTED IN CASE OF EMERGENCY AND/OR IF WE ARE UNABLE TO CONTACT THE PARENT. THIS PERSON IS AUTHORIZED TO ACT ON BEHALF OF THE PARENT REGARDING MEDICAL OR RELEASE AUTHORIZATION. THESE PERSONS MAY PICK UP THE CHILD NAMED ABOVE WITHOUT PRIOR "AT THE TIME"AUTHORIZATION FROM THE PARENTS.

NAME _____RELATION TO CHILD_____PHONE _____ _____
NAME _____RELATION TO CHILD_____PHONE _____ _____

OTHER PERSONS WHO ABOVE NAMED CHILD MAY BE RELEASED TO-UNLESS SPECIFIED, PARENTAL AUTHORIZATION IS REQUIRED. RELEASE PERSONS SHOULD BE 16 YEARS OF AGE AND PHOTO IDENTIFICATION WILL BE REQUESTED AT THE TIME OF PICK-UP.
NAME_____RELATION TO CHILD_____PHONE#1_____PHONE #2____ANYTIME____NOTES/AUTHORIZATION ONLY
_____
_____
_____

CHILD'S MEDICAL INFORMATION

DOES YOUR CHILD HAVE ALLERGIES: NO___ YES___ DESCRIBE_____
OTHER KNOWN HEALTH/DIETARY RELATED ISSUES: NO___ YES___ DESCRIBE_____
PLEASE DESCRIBE TREATMENT AND MEDICATION*: _____
_____

*(Children who have special health care needs or those who have chronic, physical, developmental, behavior or emotional conditions expected to last 12 months or more and who also require health and related services of a type beyond that required by children generally). If your child does have special health care needs, please discuss these with your child care provider-this information is also to be documented in writing by your child's medical professional on the back side of the medical form. A medical form completed by your child's health care professional and a copy of their immunization records is required at enrollment for all children. Changes in center provided food service (for medical reasons) must be documented by a health care professional on the "Medical Report of Child in Day Care" form. Rainbow Junction does not administer medication other than over the counter topical ointments, gels and lotions (see other side of this form) and inhaler and auto injector/Epi pens with parent and health care professional authorization. Medical and parent authorizations are renewable every 6 months.

CHILD'S SOURCE OF MEDICAL CARE/PRIMARY CARE PHYSICIAN_____PHONE _____
CHILD'S SOURCE OF DENTAL CARE/DENTIST _____ PHONE_____
NAME OF MEDICAL CARE FACILITY/HOSPITAL (UNLESS NOTED, SOLDIERS AND SAILOR'S MEMORIAL HOSPITAL IS USED FOR EMERGENCY AS IT IS THE CLOSEST FACILITY) 315-531-2000 _____

AGREEMENTS:

I consent to the enrollment of the child listed above in this facility and have been advised of the policies regarding administration of medications, fees, transportation and the services provided by the facility, and the Office of Child and Family Services regulations under which it operates.

1) I give consent for my child to take part in neighborhood trips (library/playground, etc) away from the facility under proper supervision **YES____ NO____**

2) In case of accident or injury, I authorize any and all medical, dental and/or surgical care and hospitalization advised by the physicians, surgeon or hospital (listed on this form) necessary for the proper health and well-being of my child **YES____ NO____**

3) I have provided information of my child's special needs (allergies, diet, disabilities and/or medical information) to the provide as may be necessary to assist the facility in properly caring for my child in case of an emergency **YES____ NO____**

4) I agree to my child's photo/pictures or artwork to be used in promotional and/or newspaper/newsletter publications **YES____ NO____**

5) I agree to my child's photo/pictures or artwork to be used on the Rainbow Junction Facebook page (no names) **YES____NO_____**

6) I agree to review and update this information whenever a change occurs and at least once every six months **YES____ NO____**

7) I authorize the director or teacher to discuss health related issues with my child's physician/office **YES____ NO____**

8) I authorize the director or teacher to discuss education related issues with my child's school staff **YES____ NO____**

SIGNATURE: PARENT OR PERSONS LEGALLY RESPONSIBLE _____DATE_____

RAINBOW JUNCTION OVER THE COUNTER MEDICATON AUTHORIZATION FORM

Child's Name _____ DOB_____

Known allergies/medical conditions and treatment, including chronic health, behavior, emotional, physical or developmental conditions_____

Physician (Health Care Professional) Name _____Telephone_____

Parent/Legal Guardian Name_____Telephone_____

Please describe any specific instructions in the spaces below for the individual items listed. Unless otherwise noted, topical ointments, lotions and gels will be applied according to the packaging instructions and provided by Rainbow Junction. If parents provide a specific item (OTC only), please list the information under the specific category. Label the container with the child's name and we must have the product insert and original container.

OTC Item	Calamine Lotion	Triple Antibiotic	Sunscreen	Bug Spray (applied to clothing only)	Hand Sanitizer	Hand/Body Lotion	Diaper Oint. Under 3 years
Child Specific OTC (provided by parent) Product Name							
Dosage							
Frequency							
How/Where Applied							
Symptoms							
Side Effects							
Other Information							

By my signature as parent/guardian for the above named child, I authorize Rainbow Junction employees to administer the named over the counter topical treatments to my child as described.

1) AT REGISTRATION: PARENT SIGN #1_____ DATE_____/_____/_____

2) AT MID TERM UPDATE: PARENT SIGN #2_____ DATE_____/_____/_____

Caregiver/Director: I have reviewed this information and have updated as needed:

Name: Andrea Bunn-Weaver Signature_____Date____/____/____INIT_____Date____/____/____

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