NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICATION CONSENT FORM

CHILD DAY CARE PROGRAMS

- This form may 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.
- Only those staff certified to administer medications to day care children are permitted to do so.
- One form must be completed for each medication. Multiple medications cannot be listed on one form.
- Consent forms must be reauthorized at least once every six months for children under 5 years of age and at least once every 12 months for children 5 years of age and older.

LICENSED AUTHORIZED PRESCRIBER COMPLETE THIS SECTION (#1 - #18) AND AS NEEDED (#33 - 35).

1. Child's First and Last Name:	2. Date of Birth: / /	3. Child's Known Allergies:
4. Name of Medication *(including strength):*	5. Amount/Dosage to be Given:	6. Route of Administration:

7A. Frequency to be administered: _____

OR

7B. Identify the symptoms that will necessitate administration of medication: *(signs and symptoms must be observable and, when possible, measurable parameters)*: _____

8A. Possible side effects: ☐ See package insert 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:

☐ Contact parent ☐ Contact health care provider at phone number provided below

☐ Other *(describe):* _____

10A. Special instructions: ☐ See package insert for complete list of special instructions *(parent must supply)*

AND/OR

10B. Additional special instructions: *(Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situation's when medication should not be administered.)* _____

11. Reason for medication *(unless confidential by law)*: _____

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and requires health and related services of a type or amount beyond that required by children generally?

☐ No ☐ Yes If you checked yes, complete (#33 and #35) on the back of this form.

13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered?

☐ No ☐ Yes If you checked yes, complete (#34 -#35) on the back of this form.

14. Date Health Care Provider Authorized: / /	15. Date to be Discontinued or Length of Time in Days to be Given: / /
16. Licensed Authorized Prescriber's Name (please print):	17. Licensed Authorized Prescriber's Telephone Number:

18. Licensed Authorized Prescriber's Signature:

X

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICATION CONSENT FORM

CHILD DAY CARE PROGRAMS

PARENT COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? *(For example, did the licensed authorized prescriber write 12pm?)* ☐ Yes ☐ N/A ☐ No

Write the specific time(s) the child day care program is to administer the medication *(i.e.: 12 pm)*: _____

20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to *(child's name):*

21. Parent's Name *(please print)*:	22. Date Authorized: / /

23. Parent's Signature:

X

CHILD DAY CARE PROGRAM COMPLETE THIS SECTION (#24 - #30)

24. Program Name:	25. Facility ID Number:	26. Program Telephone Number:

27. I have verified that (#1 - #23) and if applicable,(#33 - #36) are complete. My signature indicates that all information needed to give this medication has been given to the day care program.

28. Staff's Name *(please print)*:	29. Date Received from Parent: / /

30. Staff Signature:

X

ONLY COMPLETE THIS SECTION (#31 - #32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN (#15)

31. I, parent, request that the medication indicated on this consent form be discontinued on **/ /**
(Date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent Signature:

X

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #35)

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.

34. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date you are ordering the change in the administration of the prescription to take place.

DATE: / / _____

By completing this section, the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

35. Licensed Authorized Prescriber's Signature:

X

Learn As You Grow, Inc.

Early Childhood, Pre-Kindergarten, School Age and Camp Exploration Programs

Learn As You Grow
Child Care Centers
When Quality Matters

Enrollment Information

6 Convenient Locations

Camillus A	3711 Milton Avenue	Camillus	487-4132
Camillus B	3711 Milton Avenue	Camillus	468-1491
Solvay/West	120 N. Orchard Road	Solvay	487-0821
Syracuse	158 Highland Avenue	Syracuse	474-5627
North	5684 South Bay Road	Cicero	458-4233
Cicero	8381 Elta Drive	Cicero	699-7189

Visit us on the web at learnasyougrowccc.com

Learn As You Grow, Inc.
Early Education Centers

Name of Child _____ Date of Birth _____

Contact Information **Parent/Guardian/Responsible Person #1**

Rev. 03/2022

Name and Relationship to Child _____

Home Address _____

Cell Phone/Home Numbers _____

Employer, Address and Work Phone Number _____

_____

Parent/Guardian Email Address _____

Contact Information **Parent/Guardian/ Responsible Person #2**

Name and Relationship to Child _____

Home Address _____

Cell Phone/Home Numbers _____

Employer, Address and Work Phone Number _____

_____

Parent/Guardian Email Address _____

Person to notify when parent not available _____

Relationship to Child _____

Address _____

Phone Number _____ Cell Phone Number _____

Do you have any custody and/or visitation paperwork issued by the courts that involve your child? _____ If yes, we must have a complete copy of this paperwork placed in your child's file. This will allow us to implement the court ordered information-outlining visitation, pick up, etc. If at any time the court ordered documents are updated, we must have the complete updated copy to put on file.

Medical Information

Any health/developmental considerations we need to be aware of?_____

_____

(Any additional information we may need may be added to the back of this sheet)
Medication taken daily _____

Primary Physician _____ Phone Number _____

Primary Dentist _____ Phone Number _____

For the health and safety of all children who attend Learn As You Grow Child Care programs, all children must maintain a NYS Health Department immunization schedule based on their age.

Children with Special Needs Learn As You Grow complies with the Americans With Disabilities Act (ADA) and will provide reasonable accommodations for children with disabilities. Learn As You Grow will make individual assessments regarding whether we can meet the individual needs of the child without fundamentally altering the program. Learn As You Grow will consult with parents/guardians and professionals who work with the child in other contexts. Learn As You Grow may exclude children with disabilities from the program if a direct threat to the health or safety of others or fundamental alterations of the program are required. If your child has an IEP (Individual Education Plan) a current and up to date copy must be reviewed by Learn As You Grow prior to acceptance into the program. If accepted, a current and up to date IEP must be on file at the center at all times. The information in the IEP will allow our staff to work towards the goals set forth in the IEP. Any changes to the IEP must be reviewed by Learn As You Grow prior to continuing services. It is your responsibility to keep the most current IEP on file at the center. The ADA does not require child care centers to provide lower staff/child ratios than those set forth by the NYS Office of Children and Family Services.

Does your child have an IEP (Individual Education Plan)? _____
If yes, a current and up to date copy must be reviewed by Learn As You Grow prior to acceptance into the program. If accepted, a current and up to day IEP must be on file at the center at all times. The information in the IEP will allow our staff to work towards the goals set forth in the IEP.

Has your child ever been enrolled in child care or in-home care? If so, where and for how long?

_____

Has your child ever been enrolled at any one of the six Learn As You Grow Child Care Centers?

☐ Yes Which location? _____

☐ No How did you hear about LAYG? _____

We thank you for enrolling your child in our school. Please feel free to speak with us at any time in regard to your child's educational needs.

Parent or Guardians Signature _____ Date _____

$25.00 NON-REFUNDABLE REGISTRATION FEE IS REQUIRED WITH THIS APPLICATION AND THE FIRST WEEKS TUITION (NON-REFUNDABLE) TO GUARANTEE A SLOT.

Transportation Permission Form For Pick Up of Children

I authorize the following responsible people to pickup or drop off my child to the Learn As You Grow Early Education Centers. The people on my list will be asked to show their current photo drivers

license (or suitable photo identification). I understand that I may add or delete people from this list by submitting my request in writing to the Center Director.

1. Name _____ Phone _____
   Address _____

2. Name _____ Phone _____
   Address _____

3. Name _____ Phone _____
   Address _____

4. Name _____ Phone _____
   Address _____

5. Name _____ Phone _____
   Address _____

6. Name _____ Phone _____
   Address _____

Parent's Signature _____ Date _____

Learn As You Grow, Inc.
Early Education Centers
Transportation Plan

Rev. 03/2022

Provider Name: Learn As You Grow, Inc.
Program Name: Highland (41889) Camillus (42630/45060)
Solvay (44240) Cicero (308535)
North (113817)

Effective Date of Transportation Plan: Upon enrollment until termination of services.

This plan is designed to promote the safety of children and inform families of regulatory requirements regarding transportation. The parent will be asked to sign a separate Transportation Consent Form.

1. The program will obtain written consent from the parent(s) for any transportation of their child provided for, or arranged by a caregiver and will keep the transportation policy and the written parental consent on file at the program, and parents can be given a copy.
2. 2. A child will never be left unattended in any motor vehicle or other form of transportation.
3. Every child will board or leave a vehicle from the curb side of the street.
4. Each child will be secured in safety belts as required by law.
5. Drivers will be 18 years of age or older and hold a current valid license to drive the class of vehicle they are operating. All vehicles used to transport children must have a current registration and inspection sticker.
6. The parent(s) will be provided a copy of this plan at enrollment. If the plan changes, the parent(s) will be provided a copy of the amended transportation plan, prior to its start date. The use of cell phones or any other electronic device during transport, including hands-free devices, is prohibited. Necessary call will be made once the vehicle is parked in a legally permitted position off the road.
7. During the transportation of children, the program will adhere to the required ratio of caregivers to children at all times as determined by regulations.
8. Birnie Bus, First Student, and the local School District will provide transportation used by Learn As You Grow, Inc.

_____

Parent/Guardian Signature

Learn As You Grow
Early Education Centers
Crib to Cot to Mat Transition

The young infants sleep in their own individual crib as outlined in the Learn As You Grow Center Policies. Once the infants transition into the older infant room the children transition from cribs to cots. The infant cots are extremely low to the ground, which allows the children independence in getting on and off their cot. This transition also allows for plenty of space within the classroom for the infants to explore and play, as the cots stack neatly in the corner.

When the children are of age to transition into the toddler classroom they begin to rest on mats. Again, giving the exploring toddler ample space within the classroom.

Once the transition begins into the preschool rooms the children rest on mats. At this age the children are much more independent. They get their sheet and blanket and prepare their mat for rest.

Nap time in all age groups is a time for children to rest their bodies after a busy morning! Children are encouraged to read a book on their mat to begin to settle down. Staff will assist with rubbing backs, reading books, etc. The environments within the rooms are conducive to rest with soft music playing.

I have read and understand the Crib to Cot to Mat Transition. If I have any questions I will speak to the Director.

_____

Parent/Guardian Signature

Learn As You Grow
Early Education Centers
Daily Medications

One of the goals of Learn As You Grow Child Care Centers is to provide a safe and healthy environment for all the children enrolled in our program. This form will allow us to monitor the children for any side effects that may appear as a result of medication the children receive while not in our care. This also provides us with vital information in the event an emergency situation arises that may require outside medical care.

Please take a moment to read and complete this information then return it to the Center Director. Please be sure to inform your child's teacher if you administer any medications to your child.

Thank you in advance for assisting us in this matter.

My child, _____ does NOT receive any medications daily at home.

My child, _____ DOES receive the following medications at home (please include the name of the medication, dosage, time given and reason for this medication).

My child, _____ does NOT have any allergies.

My child, _____ DOES have allergies. (Please include documentation from your child's doctor)

I understand it is my responsibility to notify the center if my child is diagnosed with any allergies or if my child begins taking medications.

_____ _____

signature date

Learn As You Grow Early Education Centers
Authorization For Medical Treatment

Names of Minors	**Date of Birth**	**Identify Allergies/Special Conditions**

Rev. 03/2022

I/We being the parent(s) or legal guardian(s) of the above named minor(s) do hereby appoint:

Name	**Address**	**Phone**
Learn As You Grow		

To act in my/our behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above named minor(s) during the period of my/our absence from:

	through	**Termination of child care services**

This document shall be presented to a physician, dentist or appropriate hospital representative at such time as unexpected medical, dental, surgical care or hospitalization may be required.

Parent/Guardian	**Parent/Guardian**
Signature	Signature
Address	Address
Witness	**Witness**
Signature	Signature
Address	Address

Hospitalization Coverage for Above Named Minor(s):

Name of Insurance Company or Government Program

Family Physician

Name	Phone Number

Parent/Guardian Acknowledgement

These policies supersede any and all previous policies and have been written with specific intent. Any and all interpretations of these policies are governed by the consistent daily implementation of said policy.

Learn As You Grow is licensed through the New York State Office of Children and Family Services (315-423-1202) www.OCFS.ny.gov. We operate in compliance with OCFS Regulations, Learn As You Grow Policies and Best Practice. OCFS License, Regulations are posted and available at each location for your review. Please feel free to call the Center Director with any questions. Learn As You Grow (LAYG) reserves the right to modify center policies and tuition rates when necessary.

I acknowledge that I am in receipt of the revised Learn As You Grow Center Policies (revised 3/2022).

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Director Signature Date

Learn As You Grow, Inc. Early Education Centers
Early Childhood Education Tuition Contract

Center _____ Today's Date _____

Child(rens) Name _____ Weekly tuition_____

Rev. 03/2022

_____ Weekly tuition_____

_____ Weekly tuition_____

I. Agreement

A. In consideration of the promise made by _____
(parent(s)/guardian(s)/responsible party)
in paragraph 1.B below, Learn As You Grow (LAYG) Early Education Center promises that the center will provide child care services for the above named child(ren) for the period commencing _____ and ending upon 2 weeks written notice to the Center Director at the above stated weekly tuition installment rate.

***NOTE**: Rates may change at any time with a 4 week notice.

B1. In consideration of the promise made in paragraph 1.A above, I/we as the responsible parties for the above named child(ren) agree to pay the weekly tuition installments of $_____ weekly. I understand and agree that the first week's tuition and registration fee are due upon completion of this registration packet. I understand and agree that my tuition payments will be prepaid on a weekly basis. I will be using the child care center between the hours of _____ and on the following days _____.

For Department of Social Service Clients: the responsible parties for the above named child(ren) agree to pay the weekly parent fee/family share, as outlined on the most current Department of Social Services Authorization notice. The responsible parties understand and agree that the Department of Social Services will pay only for hours and days outlined on the most current Authorization notice. Any additional hours/days provided outside the scope of the DSS Authorization notice must by privately contracted with Learn As You Grow in advance of service.

C. I also agree to pay a $25.00 registration fee per family and understand that this fee is non-refundable. I also understand that my tuition payment, which will be applied towards my first week of child care, is non-refundable in the event I choose not to enroll/begin my child at Learn As You Grow.

D. All registration and child care fees are to be paid to Learn As You Grow by check or money order. No cash payments will be accepted. Learn As You Grow does not accept starter checks or any checks that are not drawn on a local bank.

II. Payment of Tuition

The following terms and conditions are also agreed to by Learn As You Grow and the above named responsible parties.

A. This is a tuition contract, which represents the purchase of a child care slot. The parent(s)/guardians(s) and/or other responsible parties agree to pay the amounts specified in this contract regardless of the child's attendance on any particular day/days for which he/she is enrolled, including absences, holidays and snow days when the center is not opened.

B. Learn As You Grow is a pre payment service provider. Payments are to be made on Friday prior to the week of service.

C. There will be a $25.00 late fee charged to the family account if payment has not been received by Wednesday morning of the current week of care.

D. Any account that is charged a late fee is considered past due. Past due accounts, including current weeks tuition and late fees, must be paid in the form of a money order for child care services to continue.

E. The following weeks tuition will also be required to be paid in the form of a money order, due to the past due status.
F. Any past due account that has not been brought current by Friday morning of the end of that week of care will result in suspension of child care services.
G. Tuition charges will continue to be applied to your account during suspension as per this contract.
H. There will be a fee for each returned check, which will be the maximum amount allowed by law.
I. In the event a client issues a check with non-sufficient funds, the check must be replaced in the form of a money order.
J. Learn As You Grow reserves the right to require all future tuition payments to be made in the form of a money order**.**
K. In the event Learn As You Grow finds it necessary to forward your account to our collection agency, you will be responsible for all collection costs and court expenses.

III. Termination of Child Care Services
The center will terminate services to the parent(s)/guardian(s) if any of the following occur:

A. An account is in arrears by one (1) week. (As per section II B and II D.)
B. Learn As You Grow Inc. reserves the right to terminate this contract and services at any time.

IV. Leaving The Program
In the event that the parent(s)/guardian(s) decide to withdraw their child(ren) from the center, it is understood that the parent(s)/guardian(s) can obtain a release from the obligations of this tuition contract by giving the center director written notice on the LAYG Withdrawal Form of that decision 2 weeks prior to the date of the child(ren) withdrawal from the center and by paying any and all weekly tuition installments, including the 2 weeks notice.

Notice of Nondiscriminatory Policy: All children of any race, color, national and ethnic origin are entitled to all the rights accorded or made available to children at the center. We do not discriminate on the basis of race, color, national or ethnic origin in administration of our educational policies, admissions policy, and other center administered programs.

This policy has been written with specific intent. Any and all interpretation of this policy is governed by the consistent daily implementation of said policy. All of the above said will be the guideline for policy interpretation.

Signatures
The above written agreement specifying the fee, manner of payment, and services to be provided must be signed by both parent(s)/guardian(s), persons having legal custody of each child or

any individual agreeing to take financial responsibility of said payments and a representative of the LAYG Early Education Center.

I/we, the undersigned, hereby affirm our intention to be bound by the provisions contained in this tuition contract.

Signatures of all responsible parties are required, as all parties will be held jointly/separately responsible.

_____	_____
Parent/Guardian Signature	date
_____	_____
Parent/Guardian Signature	date
_____	_____
Responsible Persons Signature	date
_____	_____
Directors Signature	date

This institution is an equal opportunity provider.

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 _____

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

1. _____ 2. _____ 3. _____

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 THE CHILDCARE CENTER TO COMPLETE

CACFP Agreement # _____

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 receive Federal funds based on the information I give.

Signature _____

Print Name _____

LAST FOUR (4) DIGITS OF SOCIAL SECURITY NUMBER | | | | |

Date _____

This institution is an equal opportunity provider.

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this form. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the form. The Social Security Number is not required when you: apply on behalf of a foster child; provide a SNAP, TANF or FDPIR number; or when you indicate that the adult household member signing the form does not have a Social Security Number. We will use your information to determine if the center is eligible for free or reduced-price meal reimbursement and for administration and enforcement of the Program.

INSTRUCTIONS FOR COMPLETING DOH-3688

Definition of Income

Income means income before deductions for income taxes, social security taxes, insurance premiums, charitable contributions, and bonds, etc. It includes the following: (1) monetary compensation for services, including wages, salary, commissions or fees; (2) net income from non-farm self-employment; (3) net income from farm self-employment; (4) Social Security payments; (5) dividends or interest on savings or bonds, income from estates or trusts or net rental income; (6) unemployment compensation; (7) government civilian employee or military retirement, or pensions or veteran's payments; (8) private pensions or annuities; (9) alimony or child support payments; (10) regular contributions from persons not living in the household; (11) net royalties; (12) military benefits received in cash, such as housing allowance except if you are in the Military Housing Privatization Initiative; and (13) any other cash income.

Definition of Household

Household means *family* as defined in 7 CRF 22.6.2. *Family* means a group of related or unrelated individuals who are not residents of an institution or boarding house, but who are living as one economic unit.

INSTRUCTIONS FOR PARENTS OR GUARDIANS

Write in the name of the child care center in the space provided.

Print the name of each child in your household who attends this child care center.

Section A: If anyone in your household participates in the Supplemental Nutrition Assistance Program (SNAP), receives Temporary Assistance for Needy Families (TANF) or participates in the Food Distribution Program on Indian Reservations (FDPIR), complete Section A only. Write down the SNAP, TANF or FDPIR number (do not use your ACS or DSS child care subsidy number). Then sign and date the form and return it to the day care center.

Foster children: If your household includes a foster child who is in child care, write in the names of the foster children.

Section B: Complete this section if you did not complete Section A. Write in your name and the names of all other adults and children living in the household, including unrelated people, even if they do not have any income. Do not include the children in child care who are listed at the top of the form.

Enter the amount of income each person received **last month**, before taxes or anything else was taken out. Refer to the Definition of Income and the Definition of Household, above. If any amount last month was more or less than the usual, write in that person's usual income.

The last four digits of the Social Security Number of the adult signing the certification is required. If you do not have a Social Security Number, write *none*. The form must be signed by an adult member of the household.

INSTRUCTIONS FOR SPONSORS AND CENTERS

The *For The Childcare Center To Complete* section is to be completed, signed and dated by sponsor or center staff. The sponsor/center representative must review the income eligibility form and ensure that it is completed as indicated in the instructions above. Then indicate the following:

The CACFP Agreement Number.

Total Number of Household Members – This item does not have to be completed if the parent completed Section A. Add those indicated in Section B (if completed) to the children enrolled in child care and the number of foster children, if applicable.

Total Household Income – This item does not need to be completed if the parent completed Section A. Indicate the total monthly income as calculated from Section B. If the parent chooses not to disclose income, the form must be categorized as *paid*.

Number of Free, Reduced or Paid – Compare the total household income and the total number of household members with the current year's Income Eligibility Guidelines (CACFP-3687) to determine if the household should be categorized as **Free, Reduced or Paid**. Use the appropriate column on the CACFP-3687 to categorize their income. For example, if the parent indicated biweekly income, multiply this amount by 26 to determine yearly income.

Incomplete forms (missing signatures, income information, last four digits of Social Security Number or SNAP, TANF or FDPIR numbers) are categorized in the paid category.

The income eligibility form is valid until the last day of the month one calendar year from the date it is signed by the household member. For example, a form signed on May 12, 2023 is valid until May 31, 2024.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL ALLERGY AND ANAPHYLAXIS EMERGENCY PLAN

Instructions:

- This form is to be completed for any child with a known allergy.
- The child care program must work with the parent(s)/guardian(s) and the child's health care provider to develop written instructions outlining what the child is allergic to and the prevention strategies and steps that must be taken if the child is exposed to a known allergen or is showing symptoms of exposure.
- This plan must be reviewed upon admission, annually thereafter, and anytime there are staff or volunteer changes, and/or anytime information regarding the child's allergy or treatment changes. This document must be attached to the child's Individual Health Care Plan.
- Add additional sheets if additional documentation or instruction is necessary.

Child's Name: Date of Plan: / /

Date of Birth: / / Current Weight: lbs.

Asthma: ☐ Yes (higher risk for reaction) ☐ No

My child is reactive to the following allergens:

Allergen:	**Type of Exposure**: (***i.e.***, ***air/skin contact/ingestion, etc.***):	**Symptoms include but are not limited to:** (***check all that apply***)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)

If my child was LIKELY exposed to an allergen, for ANY symptoms:

☐ give epinephrine immediately

If my child was DEFINITELY exposed to an allergen, even if no symptoms are present:

☐ give epinephrine immediately

Date of Plan: / /

THE FOLLOWING STEPS WILL BE TAKEN IF THE CHILD EXHIBITS SYMPTOMS including, but not limited to:

- **Inject epinephrine immediately and note the time when the first dose is given**.
- **Call 911/local rescue squad** (Advise 911 the child is in anaphylaxis and may need epinephrine when emergency responders arrive).
- Lay the person flat, raise legs, and keep warm. If breathing is difficult or the child is vomiting, allow them to sit up or lie on their side.
- If symptoms do not improve, or symptoms return, an additional dose of epinephrine can be given in consultation with 911/emergency medical technicians.
- Alert the child's parents/guardians and emergency contacts.
- After the needs of the child and all others in care have been met, immediately notify the office.

MEDICATION/DOSES

- Epinephrine brand or generic:
- Epinephrine dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

ADMINISTRATION AND SAFETY INFORMATION FOR EPINEPHRINE AUTO-INJECTORS

When administering an epinephrine auto-injector follow these guidelines:

- Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than the mid-outer thigh. If a staff member is accidentally injected, they should seek medical attention at the nearest emergency room.
- If administering an auto-injector to a young child, hold their leg firmly in place before and during injection to prevent injuries.
- Epinephrine can be injected through clothing if needed.
- Call 911 immediately after injection.

STORAGE OF EPINEPHRINE AUTO-INJECTORS

- All medication will be kept in its original labeled container.
- Medication must be kept in a clean area that is inaccessible to children.
- All staff must have an awareness of where the child's medication is stored.
- Note any medications, such as epinephrine auto-injectors, that may be stored in a different area.
- Explain here where medication will be stored:

MAT/EMAT CERTIFIED PROGRAMS ONLY

Only staff listed in the program's Health Care Plan as medication administrant(s) can administer the following medications. Staff must be at least 18 years old and have first aid and CPR certificates that cover all ages of children in care.

- Antihistamine brand or generic:
- Antihistamine dose:
- Other (e.g., inhaler-bronchodilator if wheezing):

***Note: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

STORAGE OF INHALERS, ANTIHISTAMINES, BRONCHODILATOR

All medication will be kept in its original labeled container. Medication must be kept in a clean area that is inaccessible to children. All staff must have an awareness of where the child's medication is stored. Explain where medication will be stored. Note any medications, such as asthma inhalers, that may be stored in a different area.

Explain here:

STRATEGIES TO REDUCE THE RISK OF EXPOSURE TO ALLERGIC TRIGGERS

The following strategies will be taken by the child care program to minimize the risk of exposure to any allergens while the above-named child is in care (add additional sheets if needed):

Document plan here:

EMERGENCY CONTACTS – CALL 911	
Ambulance: ( ) -	
Child's Health Care Provider:	Phone #: ( ) -
Parent/Guardian:	Phone #: ( ) -
CHILD'S EMERGENCY CONTACTS	
Name/Relationship:	Phone#: ( ) -
Name/Relationship:	Phone#: ( ) -
Name/Relationship:	Phone#: ( ) -

Parent/Guardian Authorization Signature:	Date: / /
Physician/HCP Authorization Signature:	Date: / /
Program Authorization Signature:	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: ☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative _____ ☐ Other _____

PHONE NUMBER(S) OF PERSON ENROLLING CHILD: ( ) - ☐ ok to text **EMAIL ADDRESS:**	ADDRESS OF PERSON ENROLLING CHILD (IF DIFFERENT THAN CHILD):

EMERGENCY INFO

EMERGENCY CONTACT NAMES / ADDRESSES	Authorized to Pick Up Child	PRIMARY PHONE NUMBER	OTHER PHONE NUMBER / EMAIL
PRIMARY CONTACT:	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text
	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text
	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ 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: ☐ None

☐ Early Intervention/Special Education ☐ Occupational Therapy ☐ Speech/Language ☐ Physical Therapy

☐ Allergies (Please list) _____

☐ 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…… ☐ Yes ☐ 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…… ☐ Yes ☐ No
- I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips…… ☐ Yes ☐ No
- I provided information on my child's special needs to the program to assist in caring for my child…… ☐ Yes ☐ No
- I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation…… ☐ Yes ☐ No
- I agree to review and update this information whenever a change occurs and at least once every year…… ☐ Yes ☐ No

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:	DATE: / /

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OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICATION CONSENT FORM

CHILD DAY CARE PROGRAMS

- This form may 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.
- Only those staff certified to administer medications to day care children are permitted to do so.
- One form must be completed for each medication. Multiple medications cannot be listed on one form.
- Consent forms must be reauthorized at least once every six months for children under 5 years of age and at least once every 12 months for children 5 years of age and older.

LICENSED AUTHORIZED PRESCRIBER COMPLETE THIS SECTION (#1 - #18) AND AS NEEDED (#33 - 35).

1. Child's First and Last Name:	2. Date of Birth: / /	3. Child's Known Allergies:
4. Name of Medication *(including strength):*	5. Amount/Dosage to be Given:	6. Route of Administration:

7A. Frequency to be administered: _____

OR

7B. Identify the symptoms that will necessitate administration of medication: *(signs and symptoms must be observable and, when possible, measurable parameters)*: _____

8A. Possible side effects: ☐ See package insert 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:

☐ Contact parent ☐ Contact health care provider at phone number provided below

☐ Other *(describe):* _____

10A. Special instructions: ☐ See package insert for complete list of special instructions *(parent must supply)*

AND/OR

10B. Additional special instructions: *(Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situation's when medication should not be administered.)* _____

11. Reason for medication *(unless confidential by law)*: _____

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and requires health and related services of a type or amount beyond that required by children generally?

☐ No ☐ Yes If you checked yes, complete (#33 and #35) on the back of this form.

13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered?

☐ No ☐ Yes If you checked yes, complete (#34 -#35) on the back of this form.

14. Date Health Care Provider Authorized: / /	15. Date to be Discontinued or Length of Time in Days to be Given: / /
16. Licensed Authorized Prescriber's Name (please print):	17. Licensed Authorized Prescriber's Telephone Number:

18. Licensed Authorized Prescriber's Signature:

X

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICATION CONSENT FORM

CHILD DAY CARE PROGRAMS

PARENT COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? *(For example, did the licensed authorized prescriber write 12pm?)* ☐ Yes ☐ N/A ☐ No

Write the specific time(s) the child day care program is to administer the medication *(i.e.: 12 pm)*: _____

20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to *(child's name):*

21. Parent's Name *(please print)*:	22. Date Authorized: / /

23. Parent's Signature:

X

CHILD DAY CARE PROGRAM COMPLETE THIS SECTION (#24 - #30)

24. Program Name:	25. Facility ID Number:	26. Program Telephone Number:

27. I have verified that (#1 - #23) and if applicable,(#33 - #36) are complete. My signature indicates that all information needed to give this medication has been given to the day care program.

28. Staff's Name *(please print)*:	29. Date Received from Parent: / /

30. Staff Signature:

X

ONLY COMPLETE THIS SECTION (#31 - #32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN (#15)

31. I, parent, request that the medication indicated on this consent form be discontinued on **/ /**
(Date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent Signature:

X

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #35)

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.

34. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date you are ordering the change in the administration of the prescription to take place.

DATE: / / _____

By completing this section, the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

35. Licensed Authorized Prescriber's Signature:

X