**THE Nursery School**
2579 Motor Pkwy.,
Ronkonkoma, NY 11779
thenurseryschools@gmail.com
631-981-5176

**TNS Academy**
35 Church St.,
Lake Ronkonkoma, NY 11779
thenurseryschools@gmail.com
631-678-5686

## Student Information

Name________________________________ D.O.B. ___________________

Home Address_____________________________________________________

Mother's Name _____________________ Cell Phone ______________________

Father's Name ______________________ Cell Phone ______________________

Email ______________________

Allergies ______________________

Nickname ______________________

Does your child prefer left or right hand? ______________________

Does your child have any special needs?______________________

What do you hope for your child to gain from this experience? __________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

Would you like to come into our class to read a story, do a craft, bake, or share a special talent?

________________________________________________________________

Parent signature__________________________ Date _______________

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

# DAY CARE ENROLLMENT

| PHOTO OF CHILD (Optional) | PROGRAM NAME: The Nursery School, TNS Academy | ADDRESS: 2579 Motor Pkwy., Ronkonkoma, 11779 35 Church St. Lake Ronkonkoma, 11779 | PHONE NUMBER: 631-981-5127, 631-678-5686 |
|---|---|---|---|
| | 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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## LIST OF PERSONS AUTHORIZED TO PICK UP CHILDREN

PROVIDER NAME: THE Nursery School, TNS Academy

PROVIDER ADDRESS: 2579 Motor Parkway, Ronkonkoma, NY 11779,
35 Church St., Lake Ronkonkoma, NY 11779

CONTACT TELEPHONE #: 631-981-5176, 631-678-5686

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PARENT/GUARDIAN NAME: ________________________________

ADDRESS: ________________________________________________________________
__________________________________________________________________________

NAMES OF CHILD(REN) ENROLLED:

________________________________
________________________________
________________________________
________________________________

NAMES AND ADDRESS OF PERSON(S) AUTHORIZED TO PICK UP CHILD:

________________________________ RELATIONSHIP TO CHILD
________________________________
________________________________ ________________________________

________________________________ RELATIONSHIP TO CHILD
________________________________
________________________________ ________________________________

________________________________ RELATIONSHIP TO CHILD
________________________________
________________________________ ________________________________

PARENT/GUARDIAN SIGNATURE: _______________________________ DATE: ___/___/____

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

| Immunization | 1st Date | 2nd Date | 3rd Date | 4th Date | 5th Date |
|---|---|---|---|---|---|
| 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

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# Napping Agreement

Dear Parents,

Please select one of the following options and sign below:

☐ I would not like my child __________________ to nap.

☐ I would like my child __________________ to have a 45-minute nap. I will provide two crib sheets and a small blanket. I understand that I must bring the blanket and sheet home on the last day of each week to wash the sheet and blanket. I will return a cleaned sheet and blanket on the first day of each week.

Parent's Signature: ________________________________

Date: ____/____/_______