

Miss Dawn's Child Care Policies

1. Miss Dawn's Child Care needs twenty-four hour notice if your child is not coming to school, or as soon as possible in an emergency situation.
2. Miss Dawn's Child Care will be notified as soon as possible if the parent will be late picking up the child.
3. The following people are allowed to pick up the child / children from Miss Dawn's Child Care:

Name: _____ Name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

4. If parents cannot be reached in an emergency situation, please contact (someone other than parents):

Name: _____ Name: _____

Phone: _____ Phone: _____

Address: _____ Address: _____

Also, we try to make your child's transition as easy as possible, so please write down any information about your child that would be helpful for us while getting to know him / her.

Parents Name: _____ Date: _____

Parents Signature: _____ Child's Start Date: _____

Miss Dawn's Child Care Contract

The following is an agreement between _____ and _____ parent

Dawn Chaffin for child care to be provided for _____ child / children

A deposit of \$_____ will hold a child care space. Deposits are not refundable. A one month trial period begins the first day of care.

1. Child care will be provided _____ from _____ days of care _____ hours of care

2. The cost of care will be \$_____ per month.

3. Payments are to be made the **first** of the month. A **late fee of \$35** will be charged for any payments made after the 10th of the month and the **provided Bank Account or Credit Card will be charged on the 11th of the month** unless other arrangements have been made between the parent and provider in writing. **Credit Cards will be charged an additional 3% processing fee.**

4. **No refunds** for absents, school closings, or vacations. There will be a **returned check fee of \$35.00 - \$50.00** charged to you if a check is returned. Lawyer fees and any legal fees will also be charged to you if a lawyer is obtained to receive monies owed to Miss Dawn's Child Care.

5. Overtime pay will be **\$1.00 a minute for each minute after 6:00 pm**, unless previous arrangements have been made between the parent and Dawn Chaffin.

6. Miss Dawn's will conduct **Fire Drills** every month and **Shelter in Place Drills** 2 times a year as per State Regulations.

7. Provider or parent can terminate this contract with a one month notice in writing.

Bank Account Info:

Account Holder Name: _____ Bank Name: _____
Routing Number: _____ Bank Account Number: _____

Credit Card Info: (3% processing fee will be added to the amount charged)

Cardholder Name: _____ Expiration Date: ____/____
Card Number: _____ Visa / MC 3 digit code: _____
Billing Address: _____ Town: _____, NY Zip: _____

Bank Account / Credit Card Holder Signature: _____ **Date:** _____

By Signing above I have given my authorization / consent to have my Bank Account/Credit Card information on file and to have my Bank Account/Credit Card debited the full tuition amount each month until the end of my child/children's care or upon written cancellation if the full tuition amount has not been fully paid by the 10th of each month. I will not dispute the manual billing of the above Bank Account/Credit Card with the Bank/Credit Card issuer so long as the amount in question was for services rendered prior to my written cancellation. I guarantee and warrant that I am the legal accountholder / cardholder for this account/credit card and that I an legally authorized to enter into this automatic billing agreement with Miss Dawn's Child Care.

My Signature below indicates that I have read, fully understand, and agree with the Policies and Procedures as stated above in this Contract.

Provider's Signature _____ Date _____

Parent's Printed Name _____ Parent's Signature _____ Date _____

EMERGENCY FORM – MUST BE NOTARIZED

Child's name _____

If the child requires medical care, the following procedures will be followed; You will be called immediately. If I cannot reach you, the child's family doctor will be called at;

Name _____

Address _____

Phone # _____

If the doctor is not available, the child will be taken to the nearest hospital emergency room for treatment.

Health Insurance Carrier

Insured's name

Policy number _____

Emergency Release Form

I hereby give my consent to Miss Dawn's Child Care to authorize medical, surgical, and/or dental treatment including hospitalization for my child _____ should it be necessary while my child is in their care.

Parent Signature _____ Date _____

Witness(Notary) _____ Date _____

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES



Medical Statement of Child in Childcare

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).

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1 st Date	2 nd Date	3 rd Date	4 th Date	5 th Date
Polio (IPV or OPV)	1 st Date	2 nd Date	3 rd Date	4 th Date	
Haemophilus influenzae type B (Hib)	1 st Date	2 nd Date	3 rd Date	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)	1 st Date	2 nd Date	3 rd Date	4 th Date	
Hepatitis B	1 st Date	2 nd Date	3 rd Date		
Measles, Mumps and Rubella (MMR)	1 st Date	2 nd Date			
Varicella (also known as Chicken Pox)	1 st Date	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.

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.

ADDITIONAL INFORMATION ON REVERSE SIDE →



Medical Statement of Child in Childcare

(continued)

Health Specifics

Comments

Are there allergies? (Specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is medication regularly taken? (Specify drug and condition)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is a special diet required? (Specify diet and condition)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any hearing, visual or dental conditions requiring special attention?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any medical or developmental conditions requiring special attention?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Summary of Physical Exam

Include special recommendations to 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 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.

Registration Form

Melville
Huntington

Child's Last Name	First	Date of Birth	Gender M/F
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Child's Last Name	First	Date of Birth	Gender M/F
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Home Address	City	State	Zip
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Home Telephone	Home Email address
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Father's Name	Occupation	Work Telephone
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Father's Cell Phone	Father's Email address
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Mother's Name	Occupation	Work Telephone
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Mother's Cell Phone	Mother's Email address
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Emergency Name (Someone other than Parents)	Relationship	Telephone Number
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Address	Town	State	Zip
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Emergency Name (Someone other than Parents)	Relationship	Telephone Number
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Address	Town	State	Zip
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I agree that in case of accident or injury, emergency medical care may be given in the event I or person designated above cannot be reached.

Signature of parent(s) _____ Date _____

_____ Date _____

Permission to Administer Over-the-Counter Topical Medications

If your child must use specific brands of any of the products listed, please indicate the brand name of the product next to the category. If any brand is acceptable just check yes, or no beside the product.

_____ YES	_____ NO	Insect Repellent
_____ YES	_____ NO	Sunscreen
_____ YES	_____ NO	First Aid Cream / Spray
_____ YES	_____ NO	Triple Antibiotic Cream / Ointment
_____ YES	_____ NO	Antiseptic Cream / Spray
_____ YES	_____ NO	Bee Sting Pads
_____ YES	_____ NO	Diaper Cream
_____ YES	_____ NO	Burn Cream

I, _____ give permission to my child care provider to apply topical Over-the-Counter medications to my child,

_____ according to label directions. I understand that the stocked brand may be used unless I have indicated a specific brand above.

This permission will be in effect from **ENROLLMENT** to **END OF CARE**.

Parent or Guardian Printed Name

Date

Parent or Guardian Signature

Date

Child Care Providers Photo/Video Consent Form

We sometimes take photographs or video footage for publicity purposes. These images may appear in our printed publications, on our website, or both. We may also send them to the news media. Before taking any pictures, we need your permission.

We may use your image(s), or those of your child(children), in our publicity material, including printed publications, videos and our website.

Miss Dawn's Child Care recognizes the need to ensure the welfare and safety of all young people enrolled at our school.

In accordance with our child protection policy we will not permit photographs, video or other images of young people to be taken without the consent of the parents/carers and children.

Miss Dawn's Child Care will take all steps to ensure these images are used solely for the purposes they are intended.

I _____ consent to Miss Dawn's Child Care
Parent/Guardian Name

photographing or videoing _____
Child/Children's Name

Please Sign _____ Date: _____
Parent/Guardian

In order to promote the safety of employees, children and visitors, as well as the security of its facilities, Miss Dawn's Child Care, Inc. may conduct 24 hour video and audio Security/Surveillance Cameras with 7 day recording of any portion of its premises at any time, the only exception being private areas of restrooms and diaper changing areas. Video cameras will be positioned in appropriate places within and around Miss Dawn's Child Care, Inc. buildings and used in order to help promote the safety and security of people and property. There will be 4 camera's located within the interior of Each Center Location (Melville Location and Huntington Location), 1 camera will be located in each classroom and 1 camera will be located by the entrance door. Miss Dawn's Childcare has installed the camera's as per the regulations. I hereby acknowledge and have been notified of the video and audio Security/Surveillance.

Signature _____ Date: _____
Parent/Guardian Name

Sleeping Arrangement Agreement

Center: *NYS Regulation 418-7(o) Other than for school age children, sleeping and napping arrangements must be made in writing between the parent and the program. Such arrangements shall include: the area of the program where the child will nap; whether the child will nap on a cot, mat, bed or a crib; and how the napping child will be supervised, consistent with the requirements of section 418-1.8 of this Subpart.*

I understand that my child _____

will sleep on a: _____ Mat _____ Pack-N-Play / Crib _____ Other

The area of the Center where my child will sleep is: (please circle one)

on a Mat on the Rug in the Child Care OR in a Pack-N-Play / Crib

All doors to the sleeping/nap room will remain open at all times. The staff are in the same room as the children when they are napping to ensure supervision.

Parent or Guardian Printed Name

Parent or Guardian Signature

Date

Provider Signature

Date