



Little Rascals Registration Form

Date: _____

(name of parent or guardian)

(address)

cell number

home number

Email address

As Deposit for: _____
(child's name) (dob)

(child's name) (dob)

Daycare Start Date: _____

Classroom: infant 1 infant 2 toddler 1 toddler 2 preschool prek

Days: Monday Tuesday Wednesday Thursday Friday

We require one week's tuition to be paid as a Security Deposit and a \$100 Registration Fee. This security and registration fee are non-refundable if you do not attend Little Rascals. After your child has attended for 4 weeks you can withdraw your child with a written request with 2 weeks notice and your security will be refunded. This security deposit will be refunded to you within 30 days from your last day at Rascals.

(signature of parent or guardian)

(Signature of daycare director)

Registration Fee: \$ _____	Payment Method:
Security Deposit: \$ _____	<input type="checkbox"/> Cash
Total Due: \$ _____	<input type="checkbox"/> Debit
Start Date: __/__/__	



Miss Tara's Little Rascals

Application For Admission

Child's Name _____ Home Tel # _____

Home Address _____

Sex: _____ D.O.B. _____

Parent 1 Name _____ Soc. Sec # _____

Employer _____ EMAIL Address _____

Work Hours _____

Address _____

Occupation _____ Work # _____ Cell# _____

Parents 2 Name _____ Soc Sec # _____

Employer _____ Work # _____ Cell# _____

Address _____

Occupation _____ EMAIL Address _____

Name of Person who is applying for Child

Relationship to Child: _____

Tuition is due every Monday! Tuition paid after it is due will be subject to a \$25.00 fee. Returned checks require the tuition paid in cash along with a \$25.00 fee. **PAYMENT IS REQUIRED FOR ANY ABSENT DAYS. NO REFUNDS** will be given for illness, vacation, holidays or snow days. Enrollment of the child requires a \$100.00 non-refundable registration fee and a 1 week tuition security fee which is non-refundable if you do not start at your estimated start date. Even with a two week notice this registration and security fee is non-refundable.

After your child has attended for 4 weeks you can withdraw your child with a written request with 2 weeks notice and your security will be refunded. This security deposit will be refunded to you within 30 days from your last day at Rascals. Rascals Day Care Center reserves the right to terminate this contract if any fees are not paid in full or if the school deems it in the best interest of both parties to do so.

Parent's Signature _____ Date _____



Miss Tara's Little Rascals

Application For Admission

Start Date _____ Referred By: _____

Days Attending: MON TUES WED THURS FRI Hours: F/T P/T

ONLY THE FOLLOWING PEOPLE ARE ALLOWED TO PICK UP MY CHILD

NAME	RELATIONSHIP	PHONE
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_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any extra names and phone numbers

Child's Physician _____ Phone _____

FIRST AID

In the event of any emergency, I authorize the staff of Rascals Daycare center to provide any first aid care deemed if necessary

SIGNATURE _____ DATE _____

EMERGENCY CARE

In the event of any emergency, I authorize the staff of Rascals Daycare center to provide any first aid care deemed if necessary

SIGNATURE _____ DATE _____

PAYMENT

In the event a child is not present payment is still required for that week.

SIGNATURE _____ DATE _____

COTS

I am allowing Little Rascals to nap my child on a cot at naptime.

SIGNATURE _____ DATE _____

BOTTLES

I am allowing Little Rascals to make the bottles for my child. The milk/formula being used is _____

SIGNATURE _____ DATE _____



Little Rascals Photographs

I, _____, give permission for photographs to be taken of my child(ren) for use within the center's program only.

Signature _____ Date _____

I, _____, give permission for photographs to be taken of my child(ren) for use on social media.

Signature _____ Date _____

Ointments/Lotions

PERMISSION TO ADMINISTER OVER-THE-COUNTER TOPICAL OINTMENTS AND LOTIONS

I, _____, parent of _____ give permission to Miss Tara's Little Rascals to apply the following, according to label directions:

_____	Yes _____	No Insect Repellent
_____	Yes _____	No Sunscreen
_____	Yes _____	No Triple Antibiotic Cream/ointment
_____	Yes _____	No Diaper Cream

If your child must have a specific brand of any of the products listed, please indicate the brand name of the product next to the category and bring it to the program (for your child's use only).

Signature _____ Date _____

Payments

I, _____, acknowledge that I am responsible for all weekly payments in the event of any kind of absense. This includes: vacations, holidays, sick days and any other absences from Miss Tara's Little Rascals.

Signature _____ Date _____



Childs Name _____

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Date _____



Little Rascals

Infant Schedule & Parent Agreement

All bottles, cups, and utensils must be labeled with child's full name. Powdered formula, ready to feed milk, juice and breast milk must be pre-measured and labeled with child's full name and expiration date.

_____ Parent prepares formula _____ Provider prepares formula

Please choose one of the following options for your infant:

_____ 1. I will provide ALL Formula, Solid Food, Water, and Juice for my infant child.

_____ 2. I will accept the provider's offer to supply meal components for my infant child.

Please Initial

I _____ give the provider permission to add warm sterilized water to powdered formula.

I _____ give the provider permission to warm milk in a bottle warmer.

I _____ give the provider permission to warm solid food.

Signatures on this form imply that both parties understand

* Children 6 months of age and under must be held during all bottle feedings

* Microwave heating of infant food and formula is prohibited by regulations.

* The Child Care Provider will make every effort to accommodate the needs of a child who is breast-fed.

Parent's Signature _____ Date _____

Provider Signature _____ Date _____



Little Rascals Classroom Information

Little Rascals

Classroom Information

FORM COMPLETED BY: _____ DATE: _____

Child's Name: First: _____ Last: _____ M/F

Date of Birth: _____ Nickname: _____

Primary Emergency Contact: _____

Telephone # _____ Cell # _____

Does your child have any allergies? Y/N

Medication _____ Food _____

Any other allergies _____

If so what are the prevailing symptoms: _____

Other important medical information _____

Brand of Formula used by the child _____

Are there parental concerns about : speech _____ hearing _____

Gross motor coordination? _____

What is your child's favorite activity? _____

Does your child have any fears? _____

What are your child's favorite toys? _____

Does your child have any temper tantrums? What does she/he do? _____

Throw up _____ Bite _____ Throw items _____ Throw himself _____

Does your child use a binky? Yes / No

Does your child need a special toy or blanket to sleep with? _____

What is your child's sleeping arrangements? _____

Does your child nap? Yes / No How long? _____

[illegible]

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: / /
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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

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: <input type="checkbox"/> Positive <input type="checkbox"/> 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	<input type="checkbox"/> Venous <input type="checkbox"/> Capillary
2 years	/ /	Result: _____ mcg/dL	<input type="checkbox"/> Venous <input type="checkbox"/> Capillary
Most recent date of lead screening (if different from above):			
	/ /	Result: _____ mcg/dL	<input type="checkbox"/> Venous <input type="checkbox"/> 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)	<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 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



Infant Feeding Schedule and Parent Agreement

All bottles, cups, and utensils must be labeled with child's full name.
Powdered formula, ready to feed milk, juice and breast milk must be pre-measured and labeled with child's full name and expiration date.

_____ Parent prepares formula

_____ Provider prepares formula

Please choose one of the following options for your infant:

_____ 1. I will provide ALL Formula, Solid Food, Water, and Juice for my infant child.

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Please Initial

I _____ give the provider permission to add warm sterilized water to powdered formula.

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I _____ give the provider permission to warm solid food.

Signatures on this form imply that both parties understand

* Children 6 months of age and under must be held during all bottle feedings

* Microwave heating of infant food and formula is prohibited by regulations.

* The Child Care Provider will make every effort to accommodate the needs of a child who is breast-fed.

Parent's Signature _____ Date _____

Provider Signature _____ Date _____

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
DAY CARE REGISTRATION

**PHOTO OF CHILD
(Optional)**

Child's Full Name:

Does your child have any allergies? ☐ Yes ☐ No

If Yes, what is your child allergic to?

Children who have special health care needs are those who have chronic physical, developmental, behavioral 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.

Child's Source of Medical Care/Primary Care Physician's Name:

Telephone Number:

Child's Source of Dental Care/Dentist's Name:

Telephone Number:

Name Of Medical Care Facility/Hospital:

Telephone Number:

Would you like information on Child Health Plus? ☐ Yes ☐ No

EMERGENCY DATA	RELATIONSHIP	CONTACT NAME	TELEPHONE NUMBER DURING CHILD CARE	OTHER TELEPHONE NUMBER (Check type)
				<input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other
				<input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other
				<input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other
				<input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other

Provider/Day Care Facility Name and Address:	CHILD'S FULL NAME:		SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	
	CHILD'S HOME ADDRESS:		DATE OF BIRTH:	
			HOME TELEPHONE NUMBER:	
	DATE OF ACCEPTANCE:		DATE OF DISCHARGE:	
	NAME OF PERSON APPLYING FOR CHILD:	<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Caretaker <input type="checkbox"/> Relative <input type="checkbox"/> Other _____	HOME TELEPHONE NUMBER:	
			DAYTIME TELEPHONE NUMBER:	
	ADDRESS OF PERSON LISTED ABOVE: (IF DIFFERENT FROM CHILD'S):			
	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 Children and Family Services regulations under which it operates. I give consent for my child to take part in neighborhood trips (i.e. library, park and playground) away from the facility under proper supervision. <input type="checkbox"/> Yes <input type="checkbox"/> No In case of accident or injury, I authorize any and all emergency medical, dental, and /or surgical care and hospitalization advised by the physicians, surgeon or hospital (listed on the other side of this card) necessary for the proper health and well-being of my child. <input type="checkbox"/> Yes <input type="checkbox"/> No I have provided information on my child's special needs (Allergies, Diet, Disabilities, and /or Medical Information) to the provider, as may be necessary to assist the facility in properly caring for my child in case of an emergency. <input type="checkbox"/> Yes <input type="checkbox"/> No I agree to review and update this information whenever a change occurs and at least once every six months. <input type="checkbox"/> Yes <input type="checkbox"/> No			
SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE		DATE:		



Little Rascals CPS Policy

Child Protective Services Policy Statement for Parents

Our philosophy is based on the premise that all children benefit from a comprehensive interdisciplinary program that fosters development and remedies problems by providing a broad range of services. The agency staff members are mandated by law to report instances of suspected child abuse and/or maltreatment. According to Section 415 of the Social Services Law staff members who suspect that a child is being abused and/or maltreated MUST make a report IMMEDIATELY at any time of the day to the State Central Register of Child Abuse and Maltreatment (SCR) maintained by the New York State Department of Social Services. While New York State requires the reporting of suspected abuse and maltreatment no state requires that the reporter have proof that the abuse or maltreatment occurred before reporting.

The undersigned has read and understands this policy

Parent's Signature

Date

This policy was explained and discussed by

Staff

Position

Date

Discipline Policy

1. Corporal punishment shall not be used, including spanking
2. No child shall be subjected to cruel or severe punishment, humiliation, or verbal abuse
3. No child shall be denied food as a form of punishment
4. No child shall be punished for soiling, wetting clothes, or not using the toilet.

We give much social reinforcement for appropriate behavior including praise, hugs, and a friendly pat-on-the back. For inappropriate behavior, the first attempt is to redirect the behavior, or the child is separated from the group and ongoing activity for a brief period. If inappropriate behavior continues to be a problem, we develop a specific program for that child while working with the parents and all staff concerned.

Parents Signature _____ Date _____