Child Care Center • Massapequa, New York

2026-2027 Registration & Enrollment Packet

WELCOME TO THE LITTLE RASCALS FAMILY!

Thank you for choosing Allstar Children's Little Rascals. Our teachers care for every child like family, and we can't wait to get to know yours. Each classroom, from our littlest infants through Pre-K, is a warm, playful place to learn, explore, and grow at your child's own pace.

This packet has everything you need to enroll: our tuition and policies, the registration forms, and a final signature page. Please complete every page, sign where indicated, and return the full packet to the front office (or email it to admin@rascalsdaycare.com) along with your annual registration fee and deposit. If you have any questions along the way, just ask Dana. We're happy to help.

Warmly,
Dana Dellicurti, Center Director

CONTACT US

Center Director	Dana Dellicurti
Address	5770 Merrick Road, Massapequa, NY
Phone	516-797-9390
Email	admin@rascalsdaycare.com
Website	rascalsdaycare.com
Hours	Before care 6:30-8:00 AM • Core day 8:00 AM-5:00 PM • Aftercare 5:00-6:00 PM

YOUR ENROLLMENT CHECKLIST

☐ Completed and signed registration packet (all pages)
☐ Annual registration fee: $100 per child, per year
☐ $500 annual deposit (applied to the last month of the contract only)
☐ Signed Autopay Authorization and Student Code of Conduct
☐ NYS “Blue Card” (OCFS-LDSS-0792), completed and signed (included)
☐ Child in Care Medical Statement (OCFS-LDSS-4433) from your child's health care provider, with immunization record (included)
☐ Non-Medication Consent (OCFS-6010), one per over-the-counter product such as sunscreen (included)
☐ Food Allergy Action Plan (if needed) and any asthma or medication care plans
☐ Copy of any custody or court orders that affect pickup or decision-making (if applicable)

Tuition & Fees

2026-2027 school year • Tuition is billed monthly by autopay

OUR DAY

Program	Hours
Before care	6:30 AM - 8:00 AM
Core day	8:00 AM - 5:00 PM
Aftercare	5:00 PM - 6:00 PM

Children may be dropped off starting at 6:30 AM (before care) and must be picked up by 6:00 PM, according to your tuition plan/schedule.

2026-2027 MONTHLY TUITION

Before care and aftercare are billed in addition to core tuition, as shown below.

Days per week	Core day 8:00-5:00	Core + before care	Core + aftercare	Core + before & aftercare
4 or 5 days*	$2,050	$2,200	$2,245	$2,350
3 days	$1,625	$1,715	$1,742	$1,805
2 days	$1,075	$1,165	$1,192	$1,255

**Our 4-day package is priced the same as 5 days. All tuition is monthly and paid by autopay.*

FEES & DEPOSIT

Item	Amount	Details
Annual registration fee	$100 per child, per year	Annual; first payment due with this packet.
Deposit	$500 per year	Applied to the last month of the contract only.
Late payment fee	$25 per day	Charged for each day tuition is unpaid after 3 days late.
Returned check fee	$40	Charged for any returned check.
Processing fees	May apply	Processing fees may apply to credit card and ACH payments.
Late pickup fee	$5 per minute	Charged after 10 minutes late. Pickup is due by 6:00 PM.
Early termination fee	$500	An additional fee for unenrolling before the contract's last month.

DISCOUNTS

- **Sibling discount:** 5% off the older child's tuition when siblings are enrolled together.
- **First responders:** Ask about our first-responder discount.

MEALS

Our chef, Jay, prepares warm, kid-friendly meals for our children right here at the center.

Center Policies

Please read carefully. You'll acknowledge these policies on the signature page.

TUITION & AUTOPAY

- Tuition is billed **monthly only**, by automatic payment (autopay). Our office will help you set up autopay at enrollment.
- Autopay runs on the **24th of each month**. Processing fees may apply for credit card and ACH payments.
- Monthly tuition is reserved for the length of the contract. You are responsible for all payments once enrolled. This includes any school closings, illnesses, holidays, vacations, and snow days.
- Tuition paid more than 3 days late is charged a late fee of $25 per day. Returned checks are charged $40.
- Children may not be permitted to attend if tuition is not paid.

DEPOSIT & WITHDRAWAL

- A $500 deposit is due each year and is applied to the last month of the contract only.
- To withdraw, please give the director **30 days' written notice**.
- A family that unenrolls before the contract's last month pays an additional $500 early termination fee.

DROP-OFF & PICKUP

- Children may be dropped off starting at 6:30 AM (before care) and must be picked up by 6:00 PM, according to your tuition plan/schedule.
- Pickup is due by 6:00 PM. A late pickup fee of $5 per minute applies after 10 minutes late.
- We release children only to parents/guardians and the authorized pickup adults listed in this packet. Photo ID will be requested. Please let us know in writing about any change.

HEALTH & SAFETY

- A current medical statement with immunization records from your child's health care provider is required before your child starts, and must be kept up to date.
- Please keep your child home when they are sick, and tell us about any allergies, medical conditions, or medications. Medication is given only with the required written authorization.
- Please update your contact, emergency, and medical information whenever anything changes.

POSITIVE GUIDANCE (DISCIPLINE POLICY)

We guide behavior with praise, encouragement, and redirection. If a child needs a moment, they may be briefly separated from the activity with a teacher nearby. If a behavior continues, we partner with you to make a plan together. Little Rascals never uses:

- Spanking or any other physical (corporal) punishment
- Cruel or severe punishment, humiliation, or verbal abuse
- Withholding food as a punishment
- Punishment for soiling, wetting, or toileting accidents

CHILD PROTECTION

Our staff are mandated reporters under New York State law. If staff suspect a child is being abused or maltreated, they must report it to the New York State Central Register of Child Abuse and Maltreatment. A reporter does not need proof before making a report.

Registration Form | Part 1: Enrollment & Child Information

Please print clearly. One form per child.

ENROLLMENT DETAILS

Date completed	Requested start date	How did you hear about us? / Referred by

Classroom (assigned by the director): ☐ Infant 1 ☐ Infant 2 ☐ Toddler 1 ☐ Toddler 2 ☐ Pre-School ☐ Pre-K

Days attending: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Number of days: ☐ 2 days ☐ 3 days ☐ 4 days ☐ 5 days

Schedule: ☐ Core day only (8:00-5:00) ☐ + Before care (6:30-8:00) ☐ + Aftercare (5:00-6:00) ☐ + Both

CHILD INFORMATION

Child's legal first name	Middle name	Last name
Preferred name / nickname	Date of birth	Sex / gender
Home address (street, city, ZIP)		Home phone
Primary language spoken at home	Other languages	Child lives with (check): ☐ Both parents ☐ Parent 1 ☐ Parent 2 ☐ Other

SIBLINGS

Sibling name	Age	Also enrolled at Little Rascals? ☐ Yes ☐ No
Sibling name	Age	Also enrolled at Little Rascals? ☐ Yes ☐ No

CUSTODY & FAMILY NOTES

Are there any custody arrangements or court orders affecting your child? ☐ No ☐ Yes (please attach a copy)

Anything else you'd like us to know about your family (optional)

Registration Form | Part 2: Parents / Guardians

PARENT / GUARDIAN 1

Full name	Relationship to child	Date of birth (optional)
Home address (if different from child's)		
Cell phone	Home phone	Email
Employer	Occupation	Work phone
Work address		Work hours

Preferred contact: ☐ Cell ☐ Text ☐ Email ☐ Work Receives billing/autopay notices? ☐ Yes ☐ No

PARENT / GUARDIAN 2

Full name	Relationship to child	Date of birth (optional)
Home address (if different from child's)		
Cell phone	Home phone	Email
Employer	Occupation	Work phone
Work address		Work hours

Preferred contact: ☐ Cell ☐ Text ☐ Email ☐ Work Receives billing/autopay notices? ☐ Yes ☐ No

PERSON COMPLETING THIS APPLICATION

Name	Relationship to child: ☐ Parent ☐ Guardian ☐ Relative ☐ Other

Registration Form | Part 3: Emergency Contacts & Authorized Pickups

EMERGENCY CONTACTS

Please list at least two adults (other than parents) we can call if we can't reach you. Emergency contacts must be able to come to the center promptly.

	Name	Relationship	Cell phone	Other phone	May pick up?
1					☐ Yes ☐ No
2					☐ Yes ☐ No
3					☐ Yes ☐ No

AUTHORIZED PICKUP

ONLY the following people (in addition to the parents/guardians listed in Part 2) may pick up my child. Photo ID will be requested.

	Name	Relationship	Phone	Password / notes (optional)
1				
2				
3				
4				
5				
6				

PEOPLE NOT AUTHORIZED TO PICK UP

If anyone may not pick up your child, list them here and attach any court order.

Name	Relationship	Notes

Registration Form | Part 4: Health & Medical Information

HEALTH CARE PROVIDERS

Child's physician / pediatrician	Practice name	Phone
Physician address		
Dentist (if any)	Phone	Preferred hospital
Health insurance provider	Policy / member #	Policyholder name

ALLERGIES

Does your child have any allergies? ☐ No ☐ Yes (If yes, please attach a care plan. For food allergies, complete the Food Allergy Action Plan in this packet with your child's health care provider.)

Food allergies	Reaction / symptoms
Medication allergies	Reaction / symptoms
Other allergies (insect stings, latex, environmental)	Reaction / symptoms

Has your child been prescribed an epinephrine auto-injector (EpiPen)? ☐ No ☐ Yes

MEDICAL CONDITIONS & MEDICATIONS

Chronic conditions (asthma, seizures, diabetes, etc.)
Medications taken regularly (name, dose, time)
Dietary restrictions (religious, cultural, medical, vegetarian, etc.)

SPECIAL SERVICES, IEP/IFSP & DEVELOPMENT

Does your child receive any special services or therapies? ☐ None ☐ Early Intervention ☐ Occupational therapy (OT) ☐ Speech/language ☐ Physical therapy (PT) ☐ Other

Does your child have an IEP or IFSP? ☐ No ☐ Yes (please share a copy so we can support your child's goals)

Provider / agency, schedule, and any developmental concerns or other services

REQUIRED HEALTH DOCUMENTS

☐ Child in Care Medical Statement (OCFS-LDSS-4433, blank form included at the end of this packet), completed by a licensed health care provider, with immunization record

☐ Lead screening results (if available) attached

☐ Food Allergy Action Plan (in this packet) and any asthma or medication care plan attached (if applicable)

Registration Form | Part 5: Getting to Know Your Child

Helps our teachers make the first days easy and happy.

PERSONALITY & PLAY

Favorite activities	Favorite toys / comfort items
Any fears?	How does your child calm down when upset?
Any concerns about speech, hearing, or motor skills?	Right- or left-handed?

When frustrated, my child may: ☐ Cry ☐ Bite ☐ Throw items ☐ Throw self down ☐ Hit ☐ Other: _____

SLEEPING

Naps? ☐ Yes ☐ No Usual nap time / length: _____ Pacifier? ☐ Yes ☐ No Special blanket or toy? ☐ Yes ☐ No

Sleep routine or tips

EATING

Eats independently? ☐ Yes ☐ No Uses: ☐ Bottle ☐ Sippy cup ☐ Open cup

Food likes	Food dislikes

TOILETING

☐ Diapers ☐ Beginning toilet training ☐ Toilet trained

During toileting my child: ☐ Sits ☐ Stands ☐ Needs help

How does your child let you know they need to go?
Anything else you'd like your child's teachers to know?

Infant Schedule & Feeding Plan

For infants and young toddlers only (6 weeks - 18 months). Skip this page if it doesn't apply.

Our infant teachers follow the schedule you use at home. Please share your baby's typical day below.

Time	Feeding (bottle / amount / food)	Nap	Notes

FEEDING

Formula / milk brand and type	Breast milk? ☐ Yes ☐ No

Bottles prepared by: ☐ Parent ☐ Little Rascals staff

☐ I will provide all formula, baby food, and other meal components for my infant.

☐ I would like Little Rascals to provide meal components for my infant.

Please label all bottles, cups, food, and utensils with your child's full name and date. Breast milk and pre-mixed formula should also be labeled with the date prepared.

Please initial:

Staff may add warm water to powdered formula.	Initials
Staff may warm bottles in a bottle warmer (never the microwave).	Initials
Staff may warm solid food (never the microwave).	Initials

Infants are held for bottle feedings, and we're happy to support breastfeeding families. Just ask.

Permissions & Consents

Please check Yes or No for each item and initial.

Permission	Details	Yes	No	Initials
First aid	Staff may provide first aid to my child when needed.	☐	☐	
Emergency medical care	In an emergency, staff may call 911 and arrange transport to the nearest hospital, and I authorize emergency medical treatment for my child if I cannot be reached. I understand that I am responsible for any resulting costs.	☐	☐	
Neighborhood walks	My child may take part in supervised walks and outings near the center (for example, the playground or park).	☐	☐	
Photos - in center	Photos of my child may be taken for use within the center (classroom displays, family updates).	☐	☐	
Photos - social media	Photos of my child may be shared on the center's website and social media.	☐	☐	
Napping	My child may nap on a cot or mat (or in an approved crib for infants) at nap time.	☐	☐	
Sunscreen	Staff may apply sunscreen according to label directions. Brand: _____	☐	☐	
Insect repellent	Staff may apply insect repellent according to label directions. Brand: _____	☐	☐	
Diaper cream	Staff may apply diaper cream according to label directions. Brand: _____	☐	☐	
Antibiotic ointment	Staff may apply over-the-counter antibiotic ointment to minor cuts and scrapes according to label directions.	☐	☐	

If your child needs a specific brand of a topical product, please bring it labeled with your child's name (for your child's use only). Prescription and other medications require a separate medication authorization form from the director.

Food Allergy Action Plan

Complete only if your child has a food allergy. To be completed with your child's health care provider.

Food allergies can be life-threatening. This plan tells our teachers exactly what to watch for and what to do, so every child with a food allergy needs one on file before their first day. Please update it whenever anything changes, and at least once a year.

Child's name	Date of birth	Weight (lbs)
Allergic to (list each food)		Asthma? ☐ Yes (higher risk of severe reaction) ☐ No

SIGNS OF AN ALLERGIC REACTION & WHAT TO DO

If you see...	Do this
SEVERE symptoms (any one): trouble breathing, wheezing, or repeated cough; throat tightness, hoarse voice, or trouble swallowing; swelling of the lips or tongue; widespread hives; pale or bluish skin, faintness, weak pulse, dizziness; repeated vomiting or severe diarrhea; feeling that something bad is about to happen; OR milder symptoms from more than one body area	1. Give epinephrine (EpiPen) immediately, if prescribed. 2. Call 911 and say the child is having an allergic reaction. 3. Keep the child lying down (or sitting up if breathing is hard). 4. Call parent/guardian and emergency contacts. 5. A second dose may be given after 5 minutes if symptoms continue, if the provider has ordered it.
MILD symptoms (one body area only): itchy or runny nose, sneezing; itchy mouth; a few hives or mild itch; mild nausea or stomach discomfort	1. Give the medication ordered below, if any. 2. Stay with the child and watch closely. 3. Call parent/guardian. 4. If symptoms get worse, give epinephrine and call 911.

Health care provider's instructions for this child (check one): ☐ Follow the steps above ☐ Give epinephrine right away if the child eats the food, even with no symptoms ☐ Other (describe)

MEDICATIONS

Epinephrine brand and dose (☐ 0.1 mg ☐ 0.15 mg ☐ 0.3 mg)	Expiration date
Antihistamine or other medication, and dose	When to give it

Please provide medication in its original pharmacy-labeled package, along with the medication consent form required by New York State. We'll let you know before any medication expires.

CONTACTS & SIGNATURES

Health care provider name	Phone	Parent/guardian phone

Health care provider signature Date Parent / guardian signature Date

Student Code of Conduct

Please read, then sign below.

Child's name	Parent / guardian name

At Little Rascals, every child, family, and teacher deserves to feel safe, welcome, and respected. Young children are still learning how to share, take turns, and handle big feelings, and we are here to help them grow those skills with patience and kindness.

EVERY CHILD AT LITTLE RASCALS HAS THE RIGHT TO:

- Take part in all activities, regardless of race, color, creed, national origin, religion, disability, gender, or sexual orientation.
- Know the classroom rules and expectations, explained by teachers in simple, age-appropriate ways and practiced every day.
- Be guided with encouragement and respect. Our teachers never use physical punishment, and never use humiliation, threats, or coercion.

WHEN BEHAVIOR AFFECTS OTHERS' SAFETY

We follow our Positive Guidance (Discipline) Policy, using praise, redirection, and teaching. If a child's behavior disrupts a safe classroom for other children or staff, here is what happens:

1. Teachers let the Center Director know about the behavior.

2. Staff who saw the incident write it down, so we can look for patterns and support your child.

3. If the behavior is unusual for your child, we'll let you know the same day.

4. If behaviors happen often and affect the safety of your child, classmates, or staff, we'll reach out to you right away and work together on a plan built on positive reinforcement.

5. If your child may benefit from support we're not able to provide (such as speech, occupational therapy, or special education services), we may ask that your child be evaluated through Early Intervention or your local school district's Committee on Preschool Special Education (CPSE). We'll gladly help you find the right next step.

6. If, after working together, we are still unable to keep all children and staff safe, Little Rascals may need to end your child's enrollment.

FAMILIES HELP TOO

We ask parents, guardians, and visitors to model the same respect at drop-off, pickup, and in all communication with staff and other families. Please bring any concerns to the Center Director so we can solve them together.

My signature below confirms that I have received and read the Little Rascals Student Code of Conduct.

Parent / guardian signature	Printed name	Date

Autopay Authorization

Monthly tuition is paid by automatic payment.

All Little Rascals tuition is paid monthly by autopay. Please complete and sign this authorization. **For your security, do not write any card or bank account numbers on this form.** Your account details are collected securely when your autopay is set up.

ACCOUNT HOLDER

Account holder name	Relationship to child
Child's name (and siblings enrolled)	Monthly tuition amount
Email for payment receipts	Phone
Autopay start month	Billing ZIP code

PAYMENT METHOD (CHECK ONE)

☐ Credit or debit card ☐ ACH (automatic withdrawal from a bank account)

Processing fees may apply for credit card and ACH payments.

AUTHORIZATION

I authorize Allstar Children's Little Rascals to automatically charge the payment method I set up:

- on the **24th of each month** for my child's monthly tuition, for the length of my enrollment contract; and
- for the fees listed on the Tuition & Fees page of this packet when they apply (including the annual registration fee, deposit, late payment fees, late pickup fees, early termination fee, and any applicable processing fees).

I understand that:

- If a payment cannot be processed, the late payment fee on the Tuition & Fees page may apply, and children may not be permitted to attend if tuition is not paid.
- I will tell the office in writing before the next draft date if my payment method changes or needs to be updated.
- Ending autopay does not end my enrollment or my responsibility for tuition. Withdrawal requires 30 days' written notice, as described in the Center Policies.

Account holder signature | Printed name | Date

Second account holder signature (if joint account) | Printed name | Date

Acknowledgement & Signatures

Please initial each statement and sign below.

I have read the Tuition & Fees page and agree to pay monthly tuition by autopay for the schedule selected in this packet.	Initials
I understand the $500 annual deposit is applied to the last month of the contract only, and the annual registration fee is $100 per child, per year.	Initials
I understand that autopay runs on the 24th of each month, and I understand the late payment fee ($25 per day after 3 days late), the $40 returned check fee, possible card/ACH processing fees, and the late pickup fee ($5 per minute after 10 minutes late; pickup is due by 6:00 PM).	Initials
I understand that 30 days' written notice is required to withdraw, and that if I unenroll before the contract's last month, I will pay an additional $500 early termination fee.	Initials
I understand that I am responsible for all payments once enrolled, including any school closings, illnesses, holidays, vacations, and snow days.	Initials
I have read and agree to the Center Policies (including drop-off/pickup, withdrawal, and health and safety), and I have signed the Student Code of Conduct and Autopay Authorization.	Initials
I have read the Positive Guidance (Discipline) Policy and the Child Protection statement.	Initials
I will provide the Blue Card, medical statement, and immunization record (and a Food Allergy Action Plan if needed), and will update them whenever anything changes.	Initials
The information in this packet is true and complete to the best of my knowledge.	Initials

PARENT / GUARDIAN SIGNATURES

Parent / Guardian 1 signature | Printed name | Date

Parent / Guardian 2 signature | Printed name | Date

CENTER USE

Center Director signature | Printed name | Date

FOR OFFICE USE ONLY			
Date received		Start date	
Annual registration fee paid		Deposit paid ($500)	
Autopay authorization signed	☐ Yes	Blue Card + 4433 on file	☐ Yes
Classroom assigned		Monthly tuition	

New York State Forms

Official NYS Office of Children and Family Services forms, included as published.

Please complete the state forms on the following pages and return them with your packet:

- **Day Care Enrollment ("Blue Card"), OCFS-LDSS-0792 (08/2019)**: emergency contacts, pickups, health care providers, and agreements. Required for every child.
- **Non-Medication Consent Form, OCFS-6010 (5/2015)**: required for each over-the-counter topical product (for example, sunscreen, diaper cream, or insect repellent). One form per product; please make copies as needed.
- **Child in Care Medical Statement, OCFS-LDSS-4433 (Rev. 06/2019)**: to be completed and signed by your child's licensed physician, physician assistant, or nurse practitioner, with immunization dates. Two pages.

Prescription and oral over-the-counter medications require a separate state medication consent form, available from the Center Director.

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: / /

OCFS-6010 (5/2015)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

NON-MEDICATION CONSENT FORM

Child Day Care Programs

- This form may be used when a parent consents to having over-the-counter products administered to their child in a child day care program. These products include, but are not limited to: topical ointments, lotions and creams, sprays, sunscreen products and topically applied insect repellant.
- This form should NOT 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. OCFS Form 7002 would meet the consent requirements for medications.
- One form must be completed for each over-the-counter product. Multiple products cannot be listed on one form.
- This form must be completed in a language in which the staff is literate.
- If parent's instructions differ from the instructions on the product's packaging, permission must be received from a health care provider or licensed authorized prescriber.

PARENT TO COMPLETE THIS SECTION (#1 - #14)

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:
4. Name of product (including strength):	5. Amount to be administered:	6. Route of administration:

7A. Frequency to be administered, include times of day if appropriate: _____

OR

7B. Identify the conditions that will necessitate administration of the product (signs and symptoms must be observable prior to administration): _____

8A. Possible side effects: ☐ See product label 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 _____

Other (describe): _____

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

AND/OR

10B. Additional special instructions: _____

11. Reason(s) for use (unless confidential by law): _____

12. Parent name (please print):	13. Date authorized:

14. Parent signature:

X

DAY CARE PROGRAM TO COMPLETE THIS SECTION (#15 - #21)

15. Program name:	16. Facility ID number:	17. Program telephone number:

18. I have verified that #1, -#14 are complete. My signature indicates that all information needed to administer this product has been given to the child day care program.

19. Staff's name (please print):	20. Date received from parent:

21. Staff's signature:

X

OCFS-LDSS-4433 (Rev. 06/2019)

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

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