Our Lady of Grace Roman Catholic Church
Angel Care • Kids of the Kingdom
666 Albin Avenue, West Babylon NY 11704
631-893-6564

WEST BABYLON SCHOOLS TRANSPORTATION DEPARTMENT

130 Nill Street, West Babylon, N.Y. 11704
Phone: 631-376-7780 Fax: 631-376-7788 or 89

CHILDCARE TRANSPORTATION REQUEST FORM FOR THE 20____ /20_____

*** This form must be renewed annually and submitted to the Transportation Department***

This form must be completed for transportation provided for any child attending kindergarten through eighth grade being cared for by a licensed childcare provider within the boundaries of the West Babylon School District or using an unlicensed childcare provider within the attendance zone of the child's school.

This form must be submitted not later than the first day of April proceeding the next school year. Forms received after April 1st will be reviewed on a case by case basis and may be approved if there is no additional cost to the district, no change in the bus route is required, and there is additional room on the bus. The district may require up to thirty (30) days to initiate any changes made after April 1st if routes have already been established.

For the safety of the student and in order to avoid the possibility for any confusion, only two caregivers are allowed per student. This is especially important for younger children who can be easily overwhelmed by revolving transportation schedules.

Please use a separate form for each child that requires childcare transportation.

Student's Name: _____ Date: _____

Parent or Guardian's Name: _____

Address: _____

Phone: Home _____ Cell _____ Work_____

Emergency Contact: _____ Phone: _____

School Attending: _____ Grade: _____

Childcare Provider's Name: _____ Phone: _____

Address: _____

I certify that all the information contained on this form is accurate and that the above named student is under my care on a regular basis.

_____ _____

Signature of Childcare Provider Date

DAYS REQUESTED

Monday _____ Tuesday _____Wednesday _____Thursday _____Friday _____ **AM Only**

Monday _____ Tuesday _____Wednesday _____Thursday _____Friday _____ **PM Only**

Monday _____ Tuesday _____Wednesday _____Thursday _____Friday _____ **AM & PM**

Childcare Provider's Name: _____ Phone: _____

Address: _____

I certify that all the information contained on this form is accurate and that the above named student is under my care on a regular basis.

_____ _____

Signature of Childcare Provider Date

DAYS REQUESTED

Monday _____ Tuesday _____Wednesday _____Thursday _____Friday _____ **AM Only**

Monday _____ Tuesday _____Wednesday _____Thursday _____Friday _____ **PM Only**

Monday _____ Tuesday _____Wednesday _____Thursday _____Friday _____ **AM & PM**

I understand that my child is not permitted to use childcare bus stops on days when he/she is not under the care and control of the above named childcare providers.

I agree to reimburse the West Babylon UFSD for its costs pursuant to the transportation of my child if it is found that he/she is not entitled to the requested childcare transportation.

_____ _____

Signature of Parent or Guardian Date

For office use only: **Date Received:** _____

Action Taken: **AM Bus** _____ **PM Bus** _____

New Covid Procedures

Sign in:

- **Children will be required to wear face covering at all times however they will be able to remove them during snack time and outside play when practicing social distancing.**
- **When parents drop children off in the a.m. (please only one parent per family and only one family at a time signing your child in at a time) Please allow enough time for dropping off the children.**
- **If your child is NOT scheduled for a day and you want to drop them off. WE WILL NOT ALLOW YOUR CHILD TO STAY (NO EXCEMPTIONS!)**
- **When signing in your child bring your own pen or sign your child in with a pen from the clean pen jar and please put it in the dirty pen jar**
- **Temperature checks will be taken before the parent leaves in the a.m. Health questions will be asked ever morning before the parent leaves. 100.3 temperature or more and the child will not be permitted to stay. 48 hours fever free and**
- **medicine free, before the child can return and in some instances a doctor's note will be required to return. If you child has any cold symptoms and you think it is due to allergies, a doctor's note will be required.**
- **Covid screening questions will be asked everyday.**
- **Hand sanitizer will be used for children before they can enter their groups.**
- **Adults must have a mask when entering.**

Please initial_____

Supplies:

- **We are collecting a $15.00 start up supply fee and a monthly $5.00 to resupply. Some supplies will include Pencils/pens, erasers, glue sticks, crayons, scissors, etc. Each child will have their own supply box.**

Please initial_____

Bathrooms:

- **Only two children in the bathroom at the same time, as always hands will be washed after each bathroom use. The toilets and sinks will be sanitized after each use. Bathrooms will be sanitized every hour.**

Please initial_____

After school care:

- **When the children come off the school bus they will have their temperature taken, go into their groups which will be a maximum of 15 children in a group with 2 counselors. The children will use the bathroom before having a snack. We will have a ½ hour homework time which will be decided by each group counselor. We will have the children outside as much as possible.**

Please initial_____

Sickness:

We will have a designated area outside of the office as our sick area.

Any child showing symptoms will be put in the designated area till a parent comes in to pick up. After you receive the call that your child is sick the child must be picked up immediately by you or someone that is on your pick up list.

If your child has one or more of these symptom please keep them home: Fever 100.3 or more, cough, runny nose, rash, sneezing, diarrhea, difficult breathing, vomiting, congestion.

Please intial_____

Child's Name:_____

Parent's Name:_____

Parent's Signature:_____

Date:_____

***We will add to these rules/procedures as the CDC and/or OCFS become available.**

OCFS-6040 (6/2020)

NEW YOK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD CARE EMPLOYEE, VOLUNTEER, PARENT, CHILD AND ESSENTIAL VISITORS HEALTH SCREENING ONE-TIME ATTESTATION

Before entering a child care program, employees, volunteers, parents, children and essential visitors ***must complete a health screening questionnaire daily. In addition, each employee, volunteer, parent, child and essential visitor must sign and submit this form to the program one time.*** Employees, volunteers, parents, children and essential visitors must answer all questions and take their temperature daily to confirm a body temperature lower than 100.0 degrees Fahrenheit. If anyone answers "Yes" to any of the questions below, they cannot enter the child care program. A parent or guardian is responsible for completing daily screening on behalf of their child(ren).

Self-Screening:

Below are the self-screening questions that employees, volunteers, parents, children and essential visitors are required to answer **daily**. If any of the answers to the below questions are "Yes," individuals **cannot** enter the program. If the answers are "No" to all the following questions, individuals may enter the program. If employees, volunteers, parents, children and essential visitors cannot take their temperature at home, but answer "No" to all other questions, they may report to the program to have their temperature taken on site.

1. Is your temperature higher than or equal to 100.0 degrees Fahrenheit?
2. Have you had any known contact with a person confirmed or suspected to have COVID-19 in the past 14 days?
3. Are you currently experiencing *ANY* of the following symptoms?
   - Cough (new or worsening)
   - Shortness of breath (new or worsening)
   - Trouble breathing (new or worsening)
   - Fever
   - Chills
   - Muscle pain (new or worsening)
   - Headache (new or worsening)
   - Sore throat (new or worsening)
   - New loss of taste
   - New loss of smell
4. Have you tested positive for COVID-19 through a diagnostic test in the past 14 days?

If you have answered "NO" to all questions, you have passed and may enter the program.

If you have answered "YES" to any question, you will not be allowed to enter the program.

Attestation: By signing this document, I agree that I will self-monitor these symptoms each day and report the outcome per the instructions above and will not enter any child care program if any of the above symptoms or conditions are present.

_____ / / _____
Signature Date

_____ / / _____
Signature Date

Note: *This document must be signed and returned to the program prior to entry. A signed copy needs to be provided only once. The child care program must retain a copy for their records.*

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Dear Angel CARE Parents,

WELCOME!!
Our Lady of Grace Angel CARE would like to welcome parents and children to our program. We would like to go over a few policies for this year that may have changed and are important for you to know. Please take the time to read the following and then sign and date the last page.

PROGRAM GOALS:

1. To provide a safe and enriching program for children
2. To encourage self-image and self-worth in each individual child.
3. To make new friends.
4. To help children develop skills to interact with peers in a positive manner.
5. To provide a consistent, daily schedule to help with feelings of security and control in the environment.
6. To offer variety of materials and activities for carrying attention spans.
7. To offer free choice activity times to foster independent choice, sharing, cooperation, and exchange of ideas
8. To offer a homework area where children may work on homework and receive assistance.
9. To enjoy games which encourage language skills and math skills.
10. To offer a variety of activity centers which encourage learning and promote the development of skills.

REGISTRATION AND PAYMENT POLICY

At time of registration, the following is required:

1. A non-refundable $75.00 registration fee per child (or $95.00 per family).
2. All required registration forms, filled out completely.
3. Both, monthly tuition fees and attendance schedules are due NO later than the 15th prior to the month of service.
   **If monthly tuition payment and attendance schedule are not received by the 15th day to the prior month of service, a $20.00 late fee will be charged.

Fees/Payment Agreement

1. The price per day is $11.00 for the first child and $10.00 for each additional child for the AM and $13 for the PM for the first child and $12 for each additional child.
2. Since September 2, 2014, there is no longer a credit back for days you have signed up for on your calendar.
3. As of May 31, 2015, we will no longer take credit cards for payments in office. You may make online credit or debit card payments using We Share. Please visit www.ourladyofgrace.net, we have information about We Share available for you upon request.

LATE PICK-UP:
We understand that emergencies can and will arise. Please arrange for emergency pick-up people that you can contact in these instances to pick up your child. They must be listed on your child's paperwork.

Parents are required to contact emergency pick up person if they suspect that they will be late picking up their child. If unsuccessful in contacting emergency pick up person, then parents must immediately contact Angel CARE Supervisor at 631-893-6564. If child is not picked up the following actions will be taken.

1. Staff will attempt to contact the alternate adult on the child's emergency card to come and pick up the child.
2. Parents will be charged $10.00 up to the first ten minutes they are late and $2.00 per minute after that.
3. PLEASE BE RESPECFUL OF OUR HARDWORKING STAFF BY BEING ON TIME!

HEALTH REMINDERS AND POLICY

Medical Policy
All children, prior to enrollment, are required to have yearly medical examinations completed and a statement from child's health care provider verifying the child to be in good health, immunizations up to date and child free from communicable disease according to the State guidelines and those of the Department of Health. Our Angel C.A.R.E. medical form includes lead-screening results for children under 6 years of age. If our findings report that a child is missing any of the necessary immunizations, the parent will be notified and required to follow up with their child's primary care physician.

Parents must submit a copy of any and all updated immunizations as your child receives them, even if your child's annual medical exam is not due yet, as per New York State Licensing Requirements.

In addition to our Health Care Plan and Procedures here at Angel C.A.R.E., we observe your child's daily physical health. If your child becomes ill or displays symptoms of illness during the day, we will immediately isolate your child from contact with other children until you pick up your child. Therefore, immediate pick up is mandatory.

Exclusion Policy
For the safety and health of your child and the other children, please do not send your child back to the facility if they:
• Have a fever or has had a fever during the previous 48 hours, especially, if fever is accompanied by behavior change, stiff neck, a rash, unusual irritability, poor feeding, vomiting or excessive crying. Fever means:

- ❖ Oral Temperature above 100.3° Fahrenheit
- ❖ Rectal Temperature above 102° Fahrenheit

- ❖ Axillary (armpit or ear) above 100° Fahrenheit
- Are still in the first 24 hours of antibiotic treatment
- Have a deep persistent cough. As long as the cough is not deep and they know to cover their mouths, there is no problem with them attending Angel CARE. We instruct children, to cough into their sleeve or arm and NOT their hands to prevent them from spreading germs further via their hands.
- Have symptoms of a possible communicable disease (RED ITCHY EYES, SNIFFLES, SORE THROAT, PAINFUL EARS, STOMACH PAIN, HEADACHE, OR DIARRHEA)
- Persistent diarrhea, defined as three or more stools in a 24 hours period, when that pattern represents:

  An increased number of stools compared to the child's normal pattern, an increase in stool water, or symptoms of dehydration (sunken eyes, dry skin, concentrated urine, small amounts of urine, or no urine in four hours); or accompanied with blood in the stool.
- Lice
- Undiagnosed skin rash and/or infected skin patches
- Vomiting two or more times in a previous 24 hour period.

Children may not return until a medical evaluation allows inclusion

Medication Policy

Prescribed medication for children with allergies, seizures or chronic illnesses will be given only with the following three items:

1. A labeled prescription bottle
2. A note from the doctor, stating the child's name, the name of the medication, the dosage, the times to administer, and a statement that the child care provider can administer medication.
3. A signed parent permission form to administer medication.

If your child has a communicable disease, please inform the Angel C.A.R.E program as soon as possible so that we can notify all parents and take the necessary disinfecting precautions here at our program.

Please note that in case of contagious illness we will notify parents by posting a notice in the building, and sending one home with each child. A child must remain out of the program for a 24 hour period, symptom free, before returning to school. If we send your child home during a session, we will send home a reminder of this precaution. Any form of viral or contagious disease that a child might have had must have a doctor's note stating the well being of the child and that the child is no longer contagious in order to return to Angel C.A.R.E.

RULES AND REGULATIONS

- Children will wear appropriate outer clothing when outside the building.
- Children will wear footwear at all times.
- Children will never under any circumstance be left without direct supervision.
- Children will never be allowed into bathrooms alone.

- While riding the bus to daily outings children will remain seated and seat belted at all times and will not cause disturbances such as yelling, throwing items, etc.
- Children will remain with his/her group leader(s) at all times, and follow all instructions given by said group leader(s).
- Children will not be physically, verbally, or otherwise abusive to any person(s) he/she comes in contact with during the course of the day. Use of foul language at anytime is strictly prohibited.
- Children will not mark, deface or otherwise destroy any property belonging to Our Lady of Grace Church or others.
- Staffing Ratio will not exceed:
  One Staff member to 9 children aged 5 years.
  One Staff member to 10 children aged 6-9 years.
  One Staff member to 11 children aged 10-12 years.

Disciplinary Policy

- It is understood that the following procedures will be employed should my child need to be disciplined for behavior while at the program:
  1st. My child will be spoken to by an adult in the Angel C.A.R.E. program.
  2nd. My child will be placed in time out for 10 minutes.
  3rd. My child will be placed in time out for an additional period of time.
  4th. After 3 notices of my child's behavioral problems I understand that he/she may be dismissed from the program.
- It is understood, I will be informed verbally and in writing of any disciplinary actions taken.

Inclement Weather Policy

- During inclement weather: Angel CARE follows the West Babylon School Schedule only. If West Babylon is closed we are closed. If West Babylon has a delayed opening 1-2 hrs, we are closed in the morning. If West Babylon has an early dismissal, we are closed in the afternoon. If West Babylon cancels all after-school activities, it will be up to our discretion whether we will remain open. We will leave a message stating if we are closed or open. We will contact West Babylon and Lindenhurst Schools with this information as well.

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POLICY AGREEMENT

- I have read, fully understand, and agree to accept the conditions set forth in Angel CARE Policies, including Program Goals, Registration/Payment Policy and Health Reminders, Medical Policy, Exclusion Policy, Medication Policy, Disciplinary Policy and the Inclement Weather Policy.
- I have read the above rules and have explained them to my child.
- I understand that should any of these be broken my child may not be allowed to continue in the Angel CARE program and I will not be monetarily reimbursed.

_____ _____

Parent/guardian signature Date

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REGISTRATION FORM

CHILD'S NAME: _____

ADDRESS: _____

TOWN & ZIP: _____

HOME PHONE: _____

DATE OF BIRTH: _____ AGE: _____

MOTHER'S NAME: _____

ADDRESS (if different than child's): _____

MARITAL STATUS* _____ E-MAIL: _____

PLACE OF EMPLOYMENT: _____

WORK PHONE #: _____ CELL PHONE # _____

FATHER'S NAME: _____

ADDRESS (if different than child's): _____

MARITAL STATUS* _____ E-MAIL: _____

PLACE OF EMPLOYMENT: _____

WORK PHONE # _____ CELL PHONE # _____

EMERGENCY CONTACT: _____ RELATION: _____

ADDRESS: _____ PHONE: _____

***DOES THE PARENT NOT LIVING WITH THE CHILD HAVE LEGAL ACCESS TO THE CHILD?**
_____ YES _____NO
If no, please supply court paperwork.

PROOF OF AGE: _____ Physical Report Form Complete: _____

REGISTRATION FEE PAID _____ METHOD OF PAYMENT _____

REGISTRATION CHECKED BY: _____

Release Authorization

Children will only be released to authorized persons on this list. The release authorization form must include the name(s) of the child's parent(s) and/or guardian(s). It is very important to keep this information updated and accurate. Inform both the office and your child's staff member(s) if there are any changes of telephone numbers, addresses, or of authorized persons as they occur.

If there are visitation issues involving the child, a copy of relevant court documents should be included with the enrollment packet.

The following persons are authorized to pick up: _____
Child's Full Name

NAME	RELATIONSHIP	TELEPHONE #	ADDRESS
	Mother		
	Father		

- An adult, with ID, listed on the child pick-up sheet will go into Fr. Shanahan Hall at the end of each day and sign my child out.
- I understand my child will not be released to anyone, (other than those listed on the child pick-up sheet).
- I understand the program ends at 6 PM and my child will be picked-up no later. There will be a late fee charged if pickup is after 6pm. If my child is not picked up by 7:00 pm he/she will be brought to the Suffolk County Police Department, 1st Pct. located at 555 Route 109, West Babylon, NY, (631)-854-8100.

_____ _____
Parent/Guardian Signature Date

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Angel CARE Emergency Plan

In the event of a serious accident or injury to a child, the Director immediately contacts the Fire/Rescue and have them send an ambulance to the center, and proceed to Good Samaritan Hospital Medical Center, ***(if your child needs emergency care while on a field trip, the Director, if unavailable, the person in charge, will call 911, request an ambulance to their location and have the child taken to the nearest hospital emergency room for treatment.)*** The Director (if unavailable, the staff person in charge) will accompany the child to the hospital with the child's medical information and emergency treatment form. The Director or their designee will call the parent (if unavailable, the emergency contact) and have them meet the child at the hospital.

Good Samaritan Hospital Medical Center is located at 1000 Montauk Hwy., West Islip.

If your child is ill while in the care of Angel CARE, but does not require emergency treatment, you will be contacted at: **HOME—WORK** (circle one).

EMERGENCY INFORMATION
Other responsible person in the event parent(s) cannot be reached:

Name: _____ Name: _____

Address: _____ Address: _____

Telephone #: _____ Telephone #: _____

DOES YOUR CHILD HAVE ANY ALLERGIES? _____Yes _____No

IF YES, PLEASE LIST:_____

_____

AUTHORIZATION FOR EMERGENCY TREATMENT
I hereby give my consent to an adult caretaker representing Our Lady of Grace Church to authorize medical, surgical, and/or dental treatment including hospitalization for my child

_____,
(Print Child's Name)
should it be necessary while my child is in the care of the Angel CARE Program.

I, _____, the parent/legal guardian of the above mentioned child, do hereby certify that the information provided is valid and agree not to hold Our Lady of Grace Church, or any employees or volunteers of Our Lady of Grace Church, responsible for any accidental injury my child might incur while in the care of the Angel CARE Program.

Parent Signature _____ Date _____

Witness (Notary) _____ Date _____

THIS FORM MUST BE NOTARIZED

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ALLERGY INFORMATION

Child's Name:_____

Is your child **allergic** to any **foods**? ☐ Yes ☐ No
Please List:_____

_____

Is your child **allergic** to any **medications**? ☐ Yes ☐ No
Please List:_____

_____

Does your child have any **seasonal allergies**? ☐ Yes ☐ No
Please List:_____

_____

Does your child have any food restrictions; e.g. religious, diet, etc.? ☐ Yes ☐ No
Please List:_____

- If a medication must be administered at the center we need authorization from the physician on the prescription form with specific instructions for administering the medication at the center. The parent or guardian must also fill out the **Permission to Give Medication** form when the medicine needs to be administered. Please come to the office immediately to update this information when there is a change.+

Permission to Administer Epipen

I am supplying an **epipen** for my child and the doctor's authorization for use (Please attach).

Allergy:_____
This epipen expires and I understand it is my responsibility to supply the Director with a new epipen at least one week prior to the expiration date. I further understand that if there are any changes in the doctor's authorization or specific directions for administration of the epipen I must notify the Center immediately.

_____ _____ _____
Date Received Date of Expiration Date Authorized

_____
Parent/Guardian Signature

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FAMILY HISTORY

Child's Name:_____

Is there anyone in the child's family who has now or ever had (Circle and indicate who):

Diabetes	Nervous Breakdown	Mental Retardation	Hemophilia
Allergy (Specify)	Heart Problems	Tuberculosis	Rheumatic Fever

Are there any diseases which seem to run in the family? _____

_____

Are the siblings in good health? _____

When mother was pregnant with child, did she have any problems? _____

Were there problems with labor and delivery? _____

Has the child had any serious accidents or illnesses? _____

Has the child ever been hospitalized or had any operations? _____

Has the child suffered any broken bones or serious burns?_____

Has the child ever taken medicines/poisons accidentally? _____

Circle any illnesses the child has had:

Measles	Whooping Cough	Black Outs	Worms
Mumps	Pneumonia	Anemia	Emotional Problems
Chicken Pox	Seizures	German Measles	

Comments: _____

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GETTING TO KNOW YOUR CHILD

Child's Name:_____

Is your child allergic to anything? _____

Has your child ever had an unusual reaction to any immunization? _____

_____

Does your child eat anything which is not food? (dirt, paint, etc.)_____

Are Medicines taken regularly? _____ Type: _____

Does your child wear glasses? _____

Does your child have persistent runny or stuffy noses or nose bleeds? _____

Does your child have frequent colds, coughs, or sore throats? _____

How does your child relate with other family members? _____

Does your child have any previous experience away from parents? _____

Describe how your child relates to other children:_____

Describe your child's personality:_____

If parents are not together, does your child see the non-custodial parent? _____

How often? _____

What are your child's strengths?_____

What are your child's weaknesses?_____

What type of discipline is practiced at home?_____

What are your child's interests?_____

How many hours per week does your child watch TV?_____

Have there been any recent deaths in the family? _____

Does your child have any scars/birthmarks?_____

_____

Photo, Quote and Video Image Release

I, (please print name)_____, give Our Lady of Grace without compensation, the absolute right and permission to use, for a period of five (5) years from signing the date, my photograph, quote and/or identity of me in Our Lady of Grace newsletters, annual report, press release, direct mail piece, website or other publications or other promotional or fundraising materials. I release Our Lady of Grace Church, the Diocese of Rockville and the Bishop thereof, their officers, employees, agents, designees, photographers, writers, the editors, the publishers from liability for any violation of any personal or proprietary right I may have in connection with such use. I am 18 years of age or older.

Child or Elder's Name:_____

Signature:_____

Address:_____

City:_____State:_____Zip:_____

Phone:_____ Date:_____

For Parent or Guardian:
I represent that I am the parent/guardian of the minor named above or the caregiver/guardian of the elder named above and agree that the grant and release contained therein binds us and said minor or elder to all of the terms thereof.

Parent/Guardian/Caregiver Signature

_____**Print Name of Parent/Guardian/Caregiver**

Address:_____

City:_____State:_____Zip:_____

Phone:_____ Date:_____

Photo Authorization:
I hereby authorize the taking of photographs for the purposes stated above.
*Release duration five (5) years from date signed
Parent/Guardian/Caregiver Signature:_____ Date:_____

I, (please print name)_____, **do not** give Our Lady of Grace permission for the above photo, quote and video release.

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Payment Agreement for Families Using DSS Child Care Subsidy

I will pay the parent fee as determined by Suffolk County Department of Social Services each Monday morning for my child's care for that week.

According to the DSS policy, "failure to pay the parent fee will lead to termination of **all** Day Care Services".

I understand that if I do not maintain the above payment schedule my care will be terminated and DSS will be notified.

_____ _____
Parent/guardian signature Date

_____ _____
Director's Signature Date

OCFS-LDSS-4433 (Rev. 4/2008) FRONT

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:

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)	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)	
Pneumococcal 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.

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)	☐ 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 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.

IMPORTANT INFORMATION!

Angel CARE Parents:

WE will be using Remind 101 in order to notify parents of any early closings, closings and all other notifications.

Below please find the information to sign up for Angel CARE Remind 101. Please sign up as soon as possible.

Thank you for your cooperation!