



Application for Admission

Child's Name: _____

Sex: _____ Date of Birth: _____

Toilet Trained: YES NO Scheduled Start Date: ____/____/____

Form of Deposit: Cash Credit Card Check

	Parent	Parent
Name:		
Home Address:		
City, State, Zip Code:		
Phone #:		
Cell #:		
***Email:		
*Emergency Pick Up Name/Information: Phone #:		

** In case of emergency, the above individual is authorized by the parent(s) to pick up a child.
The authorized individual MUST show I.D. prior to child being released.*

Medical / Allergy Information

List All Allergies Below:	List Any Pertinent Medical Conditions:

How did you learn about Steps to Success IX?

Google

Facebook

Instagram

Family Friend - Name: _____

Live Locally

Other

Please list the 3 most important qualities you look for in a day care center:

1.

2.

3.

Has your child attended daycare?

Yes

No

What type of environment do you think is best suited to support your child's growth?

**Do you have any concerns with any area of your child's development?
Please use the space below to elaborate.**

**Describe any developmental evaluations / screenings done and subsequent
approved services (Speech, OT, PT, SEIT) **For Scheduling Purposes****

Parent Signature

Date



Program Agreement Form

I, _____, parent/guardian of _____, agree to pay \$_____ for my child's attendance at Steps To Success Daycare facility.

***** I also understand that any deposits given to secure my child(ren)'s seat is non-refundable unless a 3 month notice prior to the start date is provided to Steps To Success. Furthermore, should I decide to postpone my child's start date, I understand and acknowledge that a onetime allowance is permitted for a postponement and should we decide not to attend after the postponement is granted, our deposit is relinquished immediately as the 3 month notice policy will NOT apply (the 3 month refund policy ONLY applies to the initial start date selected).**

Payment is due by the 5th of each month or I am liable for \$30.00 late fee. I understand that my child is permitted ONE (1) Vacation Week Credit (vacation time is considered 5 consecutive days and **MAY** include when Steps to Success is closed and non-operational for holidays or emergency closures) per year at no charge to me. In furtherance, I understand that my child is entitled to TWO (2) Sick Week Credits (5 consecutive school/OPERATIONAL days) per year for which I will be responsible for 50% of the tuition for that week ONLY. My year commences from the date that my child begins attending Steps to Success and will be construed as my official enrollment. I am aware that I may NOT rollover any unused sick / vacation days/credits into the following attending year. I am also aware that any credit for vacation or sick time is limited to ONLY ONE (1) week maximum per month. Sick / Vacation time is considered 5 consecutive days when Steps To Success is open and operational; hence, this excludes emergency closures. I am also aware that any credit for vacation or sick time is limited to ONLY ONE (1) week maximum per month.

Furthermore, if we are closed due to weather related conditions or events that are out of our control (i.e.: no electricity/heat, storm related disasters, floods) we are not liable and full tuition will be applied for that particular month ONLY. If we are closed due to any of the following unforeseen events below, in the first 5 days of closure, there will be no credit applied towards that month's tuition payment. In addition, we will ONLY provide credit for 50% of the remaining tuition paid for said month beyond the first 5 days. If we are closed beyond that month, you will not be required to pay tuition until our centers re-open:

- 1. Government forced shutdown
- 2. Department of Health Mandated Quarantine
- 3. Pandemics
- 4. Force Majeure

In addition, it is our policy that if you remove your child for a given month(s) you are responsible for half of the month's tuition in order to hold your child's seat. The maximum amount of days your child is permitted to attend within the month that you have notified management of non-attendance is five (5). If you go beyond the five permissible days, you will be responsible for the entire month's tuition less any applicable vacation/sick credits that you may have available and have not exhausted in the last 12 months. If your child is out for 2 consecutive weeks and we are unable to reach you and/or you have not contacted us, your child's seat is subject to being forfeited.

Finally, Steps To Success LLC, and its agents reserve the right to terminate admission into said Day Care Facility if instances arise that can potentially be harmful or threatening to children attending the facility and/or staff/management performing their duties. Moreover, should a parent/guardian of an attending child constitute a threat, either mental or physical to any of the employees, management, or a child attending said Day Care Facility, management reserves the right to preclude admission. Additionally, in the event that your child requires special needs care that we will unfortunately be unable and/or qualified to provide and once we have exhausted all options at our Center, for the betterment of your child's care and development, we will terminate services and assist in any way possible in finding alternate care.

***PRICES ARE SUBJECT TO CHANGE**

Guardian Signature

Staff Signature

____/____/____
Date



Parental Behavior and Termination of Enrollment

The well-being and safety of our staff and children are of paramount importance to us at Steps to Success. It is crucial for all members of our community to maintain a respectful, trusting and positive environment conducive to learning and growth.

Please be informed that the directors and management of Steps to Success reserve the right to terminate enrollment of any child due to the inappropriate behavior from guardians, rudeness, or harassment directed towards our staff or any member of our community. This includes, but is not limited to, demeaning remarks, threats, or excessive and unreasonable demands.

In situations where a parent or guardian exhibits such behavior, the daycare has the full authority to expel the child from our facility without any further discussions or inquiries. We appreciate your understanding and cooperation in upholding the values and standards of Steps to Success. Together, let us ensure a safe, nurturing, and respectful environment for all.

Print Name: _____

Signature: _____

Date: _____



LATE PICK-UP POLICY

At Steps to Success, the safety and well-being of all children in our care is our utmost priority. In order to maintain a structured environment for both staff and children, we have established the following Late Pickup Policy. Please read and sign this agreement to acknowledge your understanding and compliance with the outlined procedures.

Late Pickup Policy:

Designated Pickup Time: Our regular operating hours are from 7AM-6:30PM from September - June and 7:30AM-6PM for July and August. It is essential that children are picked up promptly at the end of the day.

Notification: If you anticipate being late, please notify Steps to Success as soon as possible. We understand that unforeseen circumstances can arise, and we appreciate your communication.

Emergency Contacts: If a child has not been picked up within ten minutes after closing time and we have not received any communication, our staff will begin contacting the emergency contacts listed in the child's file.

Repeated Offenses: Persistent late pickups will be considered a breach of our agreement, and further actions, including discussions with daycare management and potential termination of enrollment, may be taken.

By signing below, I acknowledge that I have read, understood, and agree to adhere to the Late Pickup Policy of Steps to Success. I understand the importance of timely pickups for the safety and well-being of all children and staff.

Print Name: _____

Signature: _____

Date: _____



Photo Release Form

Dear Families,

Steps to Success IX photographs children regularly for multiple purposes, such as:

To utilize for arts and crafts projects within the center

To send parents photos via email of daily activities performing by the children (may be individual or group)

To post on social media forums such as on our Facebook and Instagram accounts for advertising purposes.

Parents must grant Steps to Success IX permission, allowing photographs to be taken of a child for the above mentioned uses.

Please select one of the following photo - permitting options below:

- Option 1:** I grant Steps to Success IX permission to photograph my child and to use those photos on social media, to send via email, to use for montages and to utilize for an arts and crafts projects throughout the center.

- Option 2:** I Grant Steps to Success IX permission to photograph my child and ONLY use those photos to send via email, to utilize in a montage or for center based projects.





Pick Up Authorization

I (we), the parents of _____,
give my (our) consent for the following individual(s) to pick up my
(our) child if I (we) are unable to do so.

Name:	Address:	Phone #:

The following individual(s) are not allowed to up my (our) child.

1. _____
2. _____

Parent Signature:

Provider Signature:



Permission for Outdoor Activities

The Provider, Steps to Success _____, and the staff of Steps to Success _____ may take my child _____ for any activities checked below as part of the Preschool Program:

- On site playground
- Short walking trips

Parent Signature: _____

Date: _____





ILLNESS PROTOCOL

During the school year, your child may become ill. This memo is to help you along should such a circumstance occur. The information provided applies to all children admitted into our program and it is to ensure the protection of **your** child.

If your child is having a fever, diarrhea, vomiting or any other symptoms listed below, you must keep your child at home according to the policy below. This is not to punish any child, but on the contrary it is for the safety and full recovery of that child and the health and well-being of other children.

RETURNING TO SCHOOL

- Fever above 100 degrees : **24 hours fever free with no medication**
- Strep throat: **pediatrician clearance**
- Diarrhea (3 runny stools in a row) : **24 hours diarrhea free**
- Vomiting : **24 hours without vomiting**
- Consistent yellow/green mucus : **until no longer present**
- Any unusual skin rashes : **pediatrician clearance**
- Lice : **pediatrician clearance**
- Pink Eye: **24 hours on antibiotic drops**
- Severe coughing, breathing, sore throat : **pediatrician clearance**

I have read the illness protocol and returning to school protocol and will abide by it.

X

Signature



NAPPING ARRANGEMENT AGREEMENT

As per New York State regulation 418-1.7(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.

Area of Program Where Child Naps: **Classroom**

Child will Nap on a: **Cot with Sleeping Bag**

Child will be supervised by: **Teacher or Teacher Assistant**

Parent's/Caretakers Name:	Name of Child in Care:
Provider's Name:	Date of Birth:

Parent Signature: _____

Date: _____



TOPICAL CREAM CONSENT FORM

Authorization form for the application of non-prescription topical ointment or cream, including but not limited to sunscreen, insect repellent and diaper ointment. All containers are to be marked with the child's name in permanent marker. Authorization form must be completed for each non-prescription topical ointment.

Child's Name:	Date of Birth:
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I authorize **Steps to Success IX** to apply the following non-prescription topical ointment or cream to my child, as described below. I understand these products will only be applied according to the product's label. Any deviations from the label will require a physician's written authorization. For children under two years of age, please ensure their age is represented on the label or provide physician's written authorization.

Topical Ointment/Cream	Where to Be Applied	When to be applied:

Parent Signature: _____

Date: _____

ENRICHMENT PROGRAMS

Please check all programs you'd like your child enrolled in.

DANCE

Cost: \$100



2 classes weekly

GYMNASTICS

Cost: \$100



1 class weekly

KARATE

Cost: \$120



1 class weekly

*** Every child is welcome to try each class once free of charge ***

Please note that music included twice a week for all children in our program

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

	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: () - EMAIL ADDRESS:			ok to text		
			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	
Allergies (Please list)				Physical Therapy	
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: () -	
<p>Child health care information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: https://nystateofhealth.ny.gov/</p>					

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..... | | |

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:

DATE:

/ /

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician Assistant or Nurse Practitioner

Name of Child: _____	Date of Birth: / /	Date of Examination: / /
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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:	Positive Negative	mm
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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
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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